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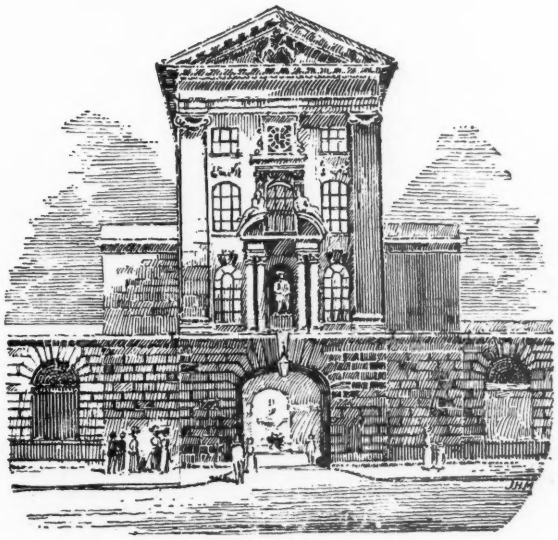
ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXXVII.—No. 5. FEBRUARY, 1930. [PRICE NINEPENCE.

CONTENTS.

	PAGE
Calendar	73
Editorial Notes	73
More Medical Notes. By Sir Thomas Horder, Bt.	74
Recent Observations on the Pituitary Body. By W. Langdon Brown, M.D., F.R.C.P.	75
The Intradermal Tuberculin Reaction. By James Maxwell, M.D., M.R.C.P. ...	80
Acknowledgments	82
Elysian Fields. By W. R. Bett, M.R.C.S., L.R.C.P.	83
Psittacosis—or Psuggestion. By C. H. A.	85
More "Clerihews." By Disparu	85
The King's Evil. By R. E. M. Fawcett	86
Abernethian Society	87
Students' Union:	
Rugby Football Club	87
Sailing Club	89
Reviews	89
Recent Books and Papers by St. Bartholomew's Men	91
Correspondence	91
Examinations, etc.	92
Changes of Address	92
Appointments	92
Births	92
Marriages...	92
Deaths	92
Index to Advertisements	ii

INDEX TO ADVERTISEMENTS.

		PAGE
Allen & Hanburys Ltd.	Ophthalmoscope	x
Alliance Drug and Chemical Co.		x
Benger's Food		iii
Books—		
Adlard & Son, Limited	The Fundus Oculi	iii
	The Puerperium	iii
Lewis, H. K., & Co., Ltd.	Circulating Library	iv
Oxford University Press	Oxford Medical Publications	iii
Boots Pure Drug Co., Ltd.	Vitamalt	v
Budd Bros.	Tailors	ii
Clinical Research Department of St. Bartholomew's Hospital		xii
Down Bros.	Specialities	xi
Evans & Witt	Booksellers, Stationers, etc.	ii
Gieves Ltd.	Royal Naval Medical Service	ii
Hall & Sons, Ltd.	"Ideal" Boots and Shoes	v
Maw, Son & Sons, Ltd.	"Tensile" Glove	iv
Medical Sickness, Annuity and Life Assurance Society, Ltd.		xii
Millikin & Lawley	Microscopes, Instruments, etc.	vii
Northwoods, Winterbourne, Bristol		ii
Paripan, Ltd.		xi
Parke, Davis & Co.	Streptococcus Antitoxin	vi
Practitioner		vii
Ronuk		vii
Shepherd, A.	Tailor and Hosier	iii
St. Bartholomew's Hospital Medical College	Preliminary Scientific Department	viii
Ditto	Scholarships; Bacteriology	viii
Ditto	Fellowship Classes; Entrance Scholarships	ix
St. Bartholomew's Trained Nurses' Institution		iii
Virol		vi

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"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

Journal.

VOL. XXXVII.—No. 5.] FEBRUARY 1ST, 1930. PRICE NINEPENCE.

CALENDAR.

Sat., Feb. 1.—Rugby Match *v.* Devonport Services. Home.
Association Match *v.* Emmanuel College, Cambridge. Home.
Mon., „ 3.—Special Subject: Clinical Lecture by Mr. Just.
Tues., „ 4.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Tues., Wed., Thurs. and Fri., Feb. 4, 5, 6 and 7.—At 8 p.m. in the Great Hall: **The Amateur Dramatic Club presents "The Mask and the Face."**
Wed., Feb. 5.—Surgery: Clinical Lecture by Mr. Harold Wilson.
Thurs., „ 6.—**Abernethian Society: Mid-Sessional Address by Prof. Barcroft, at 8.30 p.m.**
Fri., „ 7.—Dr. C. M. Hinds Howell (acting) and Mr. Harold Wilson on duty.
Sat., „ 8.—Rugby Match *v.* Old Leysians. Away.
Association Match *v.* Old Malvernians. Home.
Hockey Match *v.* R.M.C., Sandhurst. Away.
Mon., „ 10.—Special Subject. Clinical Lecture by Mr. Rose.
Tues., „ 11.—Prof. Fraser and Prof. Gask on duty.
Wed., „ 12.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.
Hockey Match *v.* Keble College, Oxford. Away.
Fri., „ 14.—Sir Percival Hartley and Sir Holburt Waring on duty.
Medicine: Clinical Lecture by Sir Percival Hartley.
Sat., „ 15.—Rugby Match *v.* O.M.Ts. Away.
Association Match *v.* University College. Home.
Hockey Match *v.* R.E., Chatham. Away.
Mon., „ 17.—Special Subject: Clinical Lecture by Mr. Elmslie.
Tues., „ 18.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Wed., „ 19.—Surgery: Clinical Lecture by Mr. Harold Wilson.
Hockey Match *v.* Epsom. Away.
Thurs., „ 20.—**Abernethian Society: Clinical Meeting, 5.30 p.m.**
Last day for receiving matter for the March issue of the Journal.
Fri., „ 21.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
Sat., „ 22.—Rugby Match *v.* Old Blues. Away.
Association Match *v.* Keble College, Oxford. Home.
Hockey Match *v.* Mill Hill. Away.
Mon., „ 24.—Special Subject: Clinical Lecture by Mr. Scott.
Tues., „ 25.—Dr. C. M. Hinds Howell (acting) and Mr. Harold Wilson on duty.
Wed. „ 26.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling
Association Match *v.* Centels (Annual Charity Match). Away.
Fri., „ 28.—Prof. Fraser and Prof. Gask on duty.
Medicine: Clinical Lecture by Sir Percival Hartley.

EDITORIAL.

Non-Professional Case-Notes.

DR. MUNDY, in a letter published elsewhere in this issue, draws attention to an account of lobar pneumonia by Arnold Bennett. Such a lay description of disease from the pen of a master of modern prose is of peculiar interest. Aldous Huxley in *Point Counter Point* has drawn unforgettably a fatal case of meningitis; and the medical man in the course of his general reading must find many like examples.

The converse question comes naturally to mind, what comment the *littérateur* would have for the strange language of professional case-notes. Accustomed to summing up the perfect specimen of Nature's masterpiece as a being of such an age and such an occupation, who looks healthy, whose pupils are equal, central and circular, whose eyes react to light and accommodation, whose *conjunctivæ* are not pale, and so through the accepted formula, our descriptive urge appears to be more easily satisfied than his. To learn from his more individual and understanding use of language might be an advantage, but the danger is lest what we look for should become as inelastic as the words in which we set down what we see.

Such discernment in favour of lay writing must not blind our eyes to the beauty of certain classical descriptions of disease, which can be culled from the canon of medicine itself. Addison's account of *Addisonian Anæmia* (1855), made current professional coin by Osler, is one of the most striking; while Paget on *Osteitis Deformans* (1877) and Gee on *The Cœliac Affection* (1888) stand out from the Bart.'s *Athenæ*. From the works of Percival Pott, readable still for their "scholarly grace and elegance" as well as for their matter, the account of a case of puffy tumour of the scalp (1760) possesses just

that picturesqueness of detail which makes it stick in the memory like a burr.

The Bible and the Plays of Shakespeare have been summoned to do the work of literary diagnosis, prognosis and treatment for long enough. An anthology of modern pen-pictures of disease would be a welcome and instructive change.

* * *

ANATOMY, ORTHODOX AND HETERODOX, IN RELATION TO SURGERY.

On Wednesday, February 19th, at 5 p.m. in the Theatre of the Royal College of Surgeons, Mr. McAdam Eccles is to deliver an Arris & Gale Lecture on the rather cryptic subject of "Anatomy, Orthodox and Heterodox, in Relation to Surgery." All students who would care to attend may do so without cards of admission. Mr. Eccles's reputation as a lucid and cogent lecturer will ensure for him an appreciative audience.

* * *

PROF. FRASER'S B.M.A. ADDRESS.

Prof. Fraser is to address fourth and fifth year students and those recently qualified in the Great Hall of the British Medical Association House, Tavistock Square, on Tuesday, February 11th, 1930. His subject, "Before the Finals: and After," is sufficiently near their hearts to make encouragement to attend superfluous. Tea will be served at 5 p.m. in the Members' Lounge, and the lecture will begin at 5.30 p.m.

* * *

Congratulations to Sir Charles Wakefield on being made a Peer. He has taken the title of Lord Wakefield of Hythe. A Governor of the Hospital in his capacity of Alderman, he was a frequent visitor to the East Wing in the days of his Mayoralty, when that wing was doing military service.

* * *

Congratulations to Dr. R. J. Brocklehurst, who has added another distinction to his already distinguished career, having been appointed to the Chair of Physiology at Bristol from August 1st, 1930.

* * *

Sir Gordon H. Campbell has offered four five guinea prizes for Fancy Dress Ball Costumes of Rahere as a Monk, as a Jester, and (*en tableau*) of Henry I handing the Charter to Rahere. The awards will be judged by photographs. Entrance forms and further details may be had from the Appeal Department at the Hospital.

* * *

The Warden requests us to state that the closing date for applications for House Appointments in May is 12 noon, Saturday, February 15th, 1930.

MORE MEDICAL NOTES.

By SIR THOMAS HORDER, Bt.

ON SOME URINARY DISEASES.

(1) The custom of collecting the twenty-four hours' urine and putting up a specimen for examination, whilst being a useful routine procedure in general cases, is far from being the best in special cases. Saving individual specimens separately as they are passed often gives valuable information in urinary diseases, especially when focal lesions are suspected.

(2) The significance of casts in the urine must be taken in relation to the question whether or no the material was centrifuged before the search is made. In the latter case the finding of an occasional hyaline or granular cast in the urine of a patient over fifty is not necessarily pathological.

(3) The odour of the urine in coliform urinary infection is so characteristic that a diagnosis can often be made by this observation alone. The smell is quite different from that of ammoniacal urine, with which it is sometimes confounded. The smell is not present in coccal infections, however severe.

(4) Relapses are so common after acute coliform infection of the urinary tract that their occurrence constitutes a feature of the disease. The presence of excess of mucus or (and) phosphates in the urine should be regarded as a danger-signal in this connection. The source of these re-infections is probably, in a considerable number of instances, a residual prostatitis.

(5) The significance of the isolation of staphylococci from the urine is quite different, according as the coccus is *S. aureus* or *S. albus*. In the former case the presence of staphylococcus pyæmia is to be suspected, with subcapsular or perinephric foci. In the latter case the coccal infection is probably secondary (to calculus, tuberculosis, gonorrhœa, etc.).

(6) It has been suggested that in albuminuria the nature of the protein helps to distinguish the "functional" from the "organic" cases, the protein being wholly or mainly serum-globulin in the former, and wholly or mainly serum-albumen in the latter. Fuller experience, however, has shown that this inquiry possesses no differential diagnostic value.

(7) The appropriate treatment of a case of "functional" albuminuria is almost the antithesis of the appropriate treatment of a case of nephritis. If, therefore, a functional albuminuric is treated as nephritic he

fails to improve. This fact sometimes seems to confirm the diagnosis of organic disease, and so the error is prolonged.

(8) It is important to remember the frequency of associated renal lesions—pyelitis with calculus, pyelitis with calculus and with neoplasm. The demonstration of pyelitis, therefore, especially if chronic or recurring, should never be accepted as a full diagnosis until other conditions have been considered and, so far as possible, eliminated.

(9) Hæmaturia in association with morbus cordis occurs in three conditions: (i) In septic endocarditis, the blood resulting from renal infarction, mostly in small (and it may be microscopic) amounts; (ii) in mitral stenosis, the blood again resulting from renal infarction, but generally in larger quantity; (iii) in dilatation, with visceral engorgement, the source of the bleeding being the renal congestion.

(10) If hæmaturia occurs in an elderly man as the result of prostatic bleeding, the condition of the prostate is more likely to be a "simple," soft, adenomatous enlargement than a carcinoma.

(11) Symptomless hæmaturia is generally due to a readily ascertained focal lesion, such as vesical papilloma, renal neoplasm or renal calculus; or it escapes explanation altogether ("essential hæmaturia").

RECENT OBSERVATIONS ON THE PITUITARY BODY.

A Clinical Lecture delivered at St. Bartholomew's Hospital.

By W. LANGDON BROWN, M.D., F.R.C.P.

IT has been well said that the progress of a science may in general be measured by the degree to which it has been put on a mathematical basis. But I should like to utter a caution against a premature attempt to do this, for not only does it convey an idea of accuracy which is wholly illusory, but it actually delays progress, because it offers a temptation to fit the facts to a mathematical formula. The kidney still refuses to work according to Ambard's coefficient, and it is still impossible to express a man's constitution in terms of pH. The equation and the graph are so mentally satisfying, things "come out" so neatly that there is a distinct temptation to apply them too soon to clinical work. Nevertheless it remains true that the nearer a science is to correct mathematical expression, the more exact it will be.

In organotherapy one is constantly struck by the great discrepancy between the confident claims of the manufacturer and the pained agnosticism of the laboratory worker. The laboratory worker not only demands proof that a gland yields an active principle in a form the body can utilize—in which he is right—but he is highly sceptical of the value of any other kind of evidence—in which he is wrong. I assert this positively, remembering that all the pioneer observations on myxœdema, acromegaly, Fröhlich's syndrome and Addison's disease were made at the bedside.

The early easy successes of thyroid administration led to an undue optimism; the problem looked much simpler than it really was. In the case of the thyroid gland we have a reservoir containing a large quantity of an active hormone, which can be assimilated by oral administration, presumably because that gland originally opened into the alimentary tract. But in other cases neither the reservoir nor the method is so adequate. Organotherapy of necessity lags behind endocrinology, which is perhaps just as well. If all the preparations which have been given had really been active much harm might have been done. But that we are going along right lines and that further advance may be expected along such lines is suggested by the way in which the results of the new work drop into place like the pieces of a jig-saw puzzle. I propose to illustrate this by some of the more recent observations on the pituitary.

We recognize the double origin of this gland from an invagination from the pharynx and a downgrowth from the brain. This suggests the possibility of its secretion being effective if given by the nasal route, just as thyroid extract is by the oral route, and this has proved to be the case. Pledgets of cotton-wool moistened with pituitrin and placed high up in the nose can control diabetes insipidus, while more recently a snuff containing dried and powdered pituitary gland substance has also been successful.

Physiologically we must distinguish between anterior lobe, posterior lobe and the stalk. The pars intermedia seems functionally to belong to the posterior lobe. It has been known for a good many years that the anterior lobe contains both eosinophile and basophile cells; it has also been recognized that this lobe is concerned with both growth and sexual development. But now H. M. Evans and M. B. Simpson have been able to separate a distinct hormone for each of these functions and to associate them with a particular type of cell. Moreover,

[NOTE.—The illustrations from Prof. Cushing's Oration before the Medical Society in 1927 are published here, by kind permission, from the Society's *Transactions*, vol. 50.]

there is a definite antagonism between them, the growth hormone being capable of completely nullifying the other if they are simultaneously injected. Nature has provided the necessary adjustment in the relative amounts of the two substances secreted. That growth precedes sexual maturity is presumably due to the early predominance of the growth hormone. The retardation of sexual maturity in the interest of somatic growth is

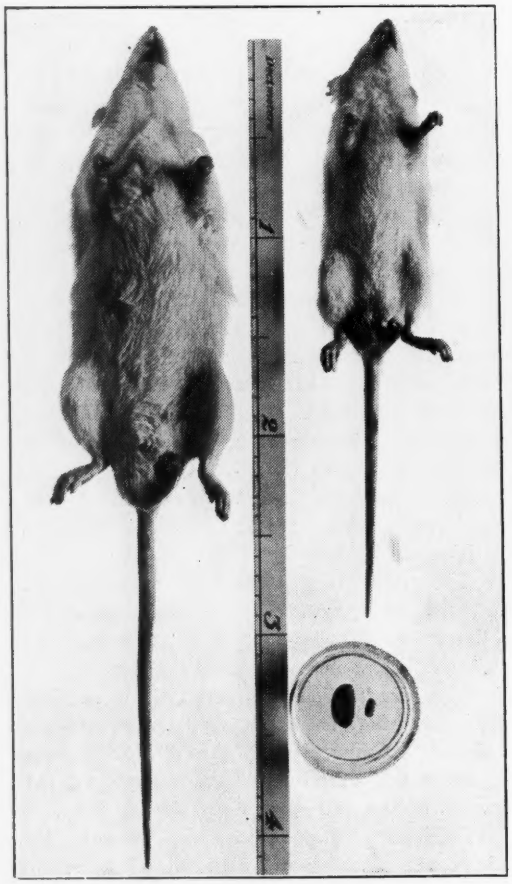


FIG. 1.—LITTER-MATE BROTHERS; 3 MONTHS AFTER REMOVAL OF THE PITUITARY FROM THE ONE ON THE RIGHT.—(P. E. SMITH.)

similarly determined by the action of the pineal body and the thymus gland. The association between the eosinophile cells and growth is indicated by the coincidence of eosinophilous adenoma with gigantism or hemihypertrophy if it develops before the epiphyses join up, and acromegaly if it develops after this date, while a definite relationship has been established between the basophile cells and the gonads. When the basophile cells are able to assert themselves over the eosinophile cells, puberty occurs. Transplantation of gonads is only effective when there is also such an active anterior pituitary to maintain their activity. Injection of anterior pituitary extract will cause sexual development in the young and restoration of function in the old.

It is noteworthy that over-activity of the anterior pituitary as expressed in basophilic adenomas tends, like adrenal cortical tumours, to produce virilism. I

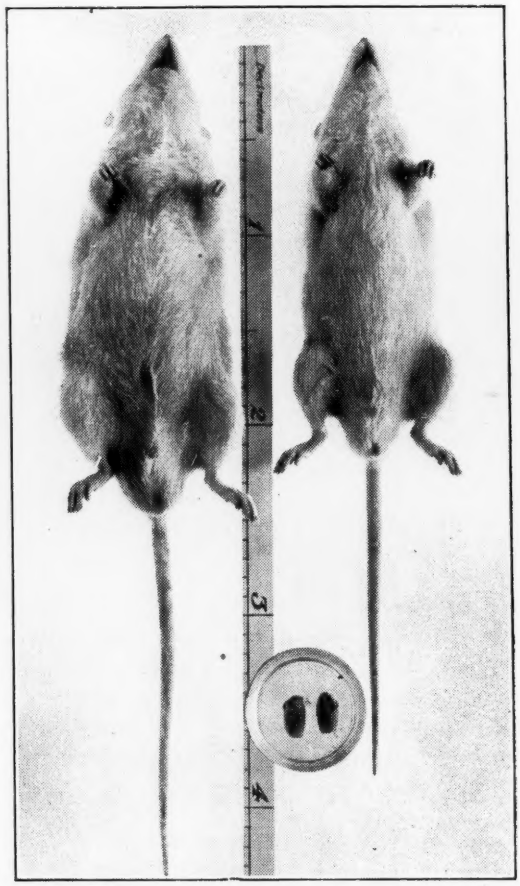


FIG. 2.—THE SAME 3 MONTHS LATER SHOWING THE EFFECT OF PITUITARY TRANSPLANTS ON THE ANIMAL FROM WHICH THE PITUITARY HAD BEEN REMOVED.—(P. E. SMITH.)

have reported cases of virilism in women due to this cause.

Before Evans and Simpson had thus separated the functions of the anterior lobe P. E. Smith had carried out some interesting observations on rats. He removed the pituitary from one of two litter-mate brothers. Fig. 1 shows the effect on the growth of the whole body and of the testes three months after this operation. The dwarfed and sexually infantile animal then had a pituitary

transplanted into him each day. In another three months he had almost caught up his brother in growth, and the remaining testis was almost the same size in both animals (see Fig. 2).

This would lead us to associate dwarfism without sexual hypoplasia, as distinct from infantilism, with a defective development of the eosinophile cells of the anterior pituitary, and I have seen dwarfs in which the pituitary fossa was small. But the most convincing evidence was supplied by Simmonds of Hamburg in 1914. He pointed out the frequency with which the pituitary, in the course of septic infections, may be affected by embolic processes. The symptoms naturally vary with the age of onset. His first series of cases had chiefly occurred in consequence of puerperal sepsis. In one instance the patient's premature senility, somnolence and death were found to be associated with almost complete cicatricial destruction of the gland. The viscera were atrophic, in sharp contrast with the splanchnomegaly of acromegaly.

If such an infarct occurs in childhood and involves only the anterior lobe the results are even more striking. In 1918 Simmonds reported a case of a dwarf, only 2 ft. 11 in. in height, who died at the age of 21. These patients may show an extraordinary premature senility, as first described by Jonathan Hutchinson, and subsequently more fully by Hastings Gilford under the name of "progeria," signifying premature old age. The "enfeebled old dotard of five" of the "Bab Ballads" is an example of this. Some of these cases show a failure of the adrenal cortex to develop, and the condition has been referred to this failure. But it would appear to be equally liable to

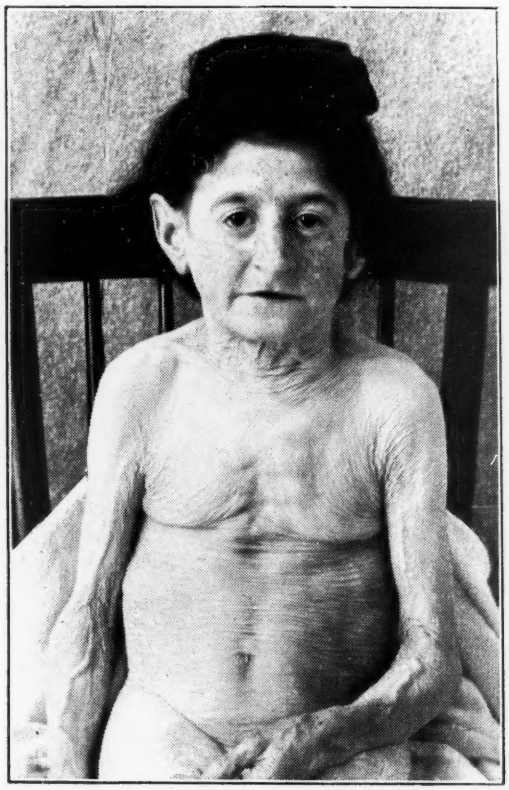


FIG. 3.—PATIENT AGED 8, SUFFERING FROM PROGERIA.—(CUSHING.)

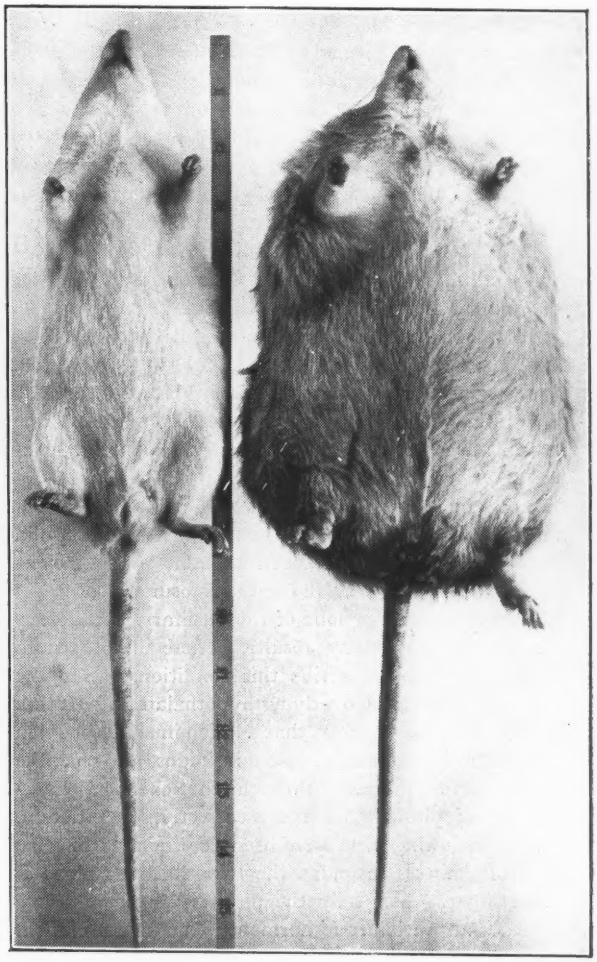


FIG. 4.—LITTER-MATE SISTERS; THE ONE ON THE RIGHT WAS SUBJECTED TO A LESION OF THE HYPOTHALAMUS, WITHOUT REMOVAL OF THE PITUITARY, 22 DAYS BEFORE THE PHOTOGRAPH WAS TAKEN.—(P. E. SMITH.)

result from damage to the anterior pituitary. It is interesting to note that just as basophilic over-growth of the anterior pituitary or adrenal cortical tumours may produce premature sexual development always tending to virilism, so lack of anterior pituitary (presumably eosinophilic) or of adrenal cortex may lead to dwarfism with premature senility. Fig. 3, a case of Cushing's in a patient aged 8, shows this premature senility very well.

The posterior lobe produces an active secretion to which the name "pituitrin" has been given. But some two years ago it was established by the researches of Kamm and others that this really contained two active principles, one *oxytocin* or *pitocin*, which stimulates the contraction of uterine muscle, the other *vaso-pressin* or *pitressin*, which raises blood-pressure, affects diuresis and antagonizes insulin. Both these principles have been isolated in the form of white, stable water-soluble powders. The chemical processes involved do not alter the original active principle or principles, since they can be recombined to form a pituitary extract identical with the original form from which they were prepared. Overaction of the posterior lobe may lead to pituitary glycosuria, which is often characterized by its rhythmic intermittence, and by bony changes indicating that the anterior lobe is involved. Rhythm is typical of pituitary (note its association with the menstrual cycle), and the definite antagonism between pituitrin and insulin first described by J. H. Burn explains why an overproduction of pituitrin will excite glycosuria.

When the posterior lobe of the pituitary is in defect, diabetes insipidus may result. There has been a tendency of late to ascribe this condition, not to the pituitary, but to the overlying hypothalamus. I think the evidence clearly shows that a lesion in either position is capable of producing diabetes insipidus, and that the hypothalamus operates through the chemical intermediary of pituitrin, or more correctly, of pitressin. For the following facts have been determined: in some cases of diabetes insipidus the hypothalamus alone is damaged, in others only the pituitary; the pituitary produces an antidiuretic hormone; this hormone will act on the denervated kidney. This last fact proves, to my mind, that even when the hypothalamus is responsible, it must act, not through a nervous, but through a chemical mechanism, and that this mechanism resides in the underlying pituitary.

With regard to oxytocin, it is important to note Dixon and Marshall's observations on the effect of the interstitial hormone of the ovary in stimulating its secretion, and to the inhibitory effect of the luteal hormone upon it. In this way the presence of the corpus luteum provides for the maintenance of pregnancy, and, as Fränkel's earlier experiments showed, its destruction is inevitably followed by abortion. When the corpus luteum begins to undergo fatty degeneration it no longer exerts this inhibitory effect, and the interstitial hormone initiates parturition through the pituitary. As Dixon says, it is remarkable that medical men, in using pituitary extract to stimulate uterine contractions, should have adopted the method which Nature has employed from time immemorial. And it may be added that they used it empirically before this chain of events was known.

In this same way the pituitary seems necessary to the involution of the uterus after pregnancy, and Leslie Pugh has found that failure of the corpus luteum of the cow to atrophy led to subinvolution.

It is not clear yet whether the so-called galactogogue effect of pituitrin is due to pitocin or pitressin. It is usually stated that this is merely due to a contraction of the muscles in the mammary ducts, but this would hardly account for three cases of pituitary tumour I have seen associated with lactation lasting seven, three and two years respectively. In the latter two cases administration of extract of corpus luteum promptly checked the secretion of milk. The other case I only saw in the post-mortem room.

The sharp bitemporal headache sometimes suddenly experienced by a woman on putting the child to the breast appears to be due to the demand made upon the pituitary, and I have known it to be relieved by pituitary extract.

Much light has been thrown on the pathology of Fröhlich's syndrome by another of P. E. Smith's experiments on rats. Fig. 4 shows the result of an injury to the hypothalamus without damage to the pituitary itself. The animal became enormously fat, while the sexual apparatus atrophied. It would therefore appear that the essential features of Fröhlich's syndrome can be produced by merely interfering with the relations between the pituitary and the hypothalamus. I put it in this way because it appears to me probable that it is interference with the communication between the gland and the central canal system of the brain that is directly responsible. But in Fröhlich's syndrome the functions of both lobes must be interfered with, for sex is associated with the anterior lobe, and that pituitrin produced by the posterior lobe helps in the transport of fat. Leathes found that saturated fat is sent from the tissue depôts to the liver to be desaturated before it can be metabolized; hence the accumulation of saturated fat in the liver in hepatic toxæmias. Coope proved that an injection of pituitrin was followed by a transference of fat from the tissue depots to the liver. We can therefore understand why

the subject of hypopituitarism becomes obese, for the tissue fat cannot be properly metabolized. And as we know, this fat tends to accumulate, particularly round the limb girdles. From the close association between the gonads and the pituitary we can understand why castration or gonadal defects lead to obesity. But many cases of Fröhlich's syndrome have been due to a chromophobe adenoma in the pituitary. Last year I saw a man who had recently become obese, and had developed large mammæ. He had lost most of the hair on his body and his genitals had shrunk. An X ray showed his pituitary fossa to be definitely enlarged. He was evidently suffering from an adenoma of this sort, but I did not venture to advise operation. However, this was subsequently carried out, and I am informed that his condition has returned to normal.

insipidus following lethargic encephalitis, which may attack this region.

Again Cushing regards wide-spread pluriglandular syndromes as specially characteristic of pituitary disorders, and as differentiating them from the disorders primarily affecting any other of the ductless glands. But before we unravel such complexities, it is essential to have a clear impression of the ordinary functions of each lobe and of the results of increase or diminution of each of these functions. It is in the hope of clarifying those impressions that I have drawn up a table embodying the results of recent investigations.

A few words in conclusion on the psychological accompaniments of pituitary diseases. It is curious that many of these are the same whether associated with excess or defect of pituitary activity. In fact we

Table of Pituitary Functions and Diseases.

	Secretion.	Diseases from— Over-action.	Under-action.
Anterior lobe	Growth hormone from eosinophilic cells	Gigantism Hemihypertrophy Acromegaly	Dwarfism. Progeria.
	Sex hormone from basophilic cells	Virilism in women	Of both lobes. Fröhlich's syndrome.
Posterior lobe	Pitocin, contracting the uterus		Some cases of subinvolution of the uterus.
	Pitressin, raising blood-pressure, affecting diuresis and antagonizing insulin	Pituitary glycosuria	Diabetes insipidus.

It is interesting to note that while chromophile adenomas are associated with increased function, the chromophobe ones lead to diminished function of the gland. This suggests that the former are homoplastic and composed of true secreting cells, while the latter are heteroplastic and merely act as foreign bodies.

It is clear that mixed conditions may be produced of a puzzling kind. Thus pressure effects may be associated with a chromophile tumour, which causes symptoms of hyperpituitarism, or with a cyst or chromophobe tumour, causing symptoms of hypopituitarism. Further, the over-action of one lobe may first irritate and then suppress the function of the other by pressure on it, while the over-acting lobe may itself subsequently pass into a condition of exhaustion. Moreover, hypothalamic damage may lead to hypopituitary symptoms. Thus recent work on the effects of damage to the hypothalamus explains the cases of obesity and diabetes

can in general only speak of the psychological effects of *dyspituitarism*. It is true that a well-developed anterior lobe is often associated with an imaginative force which can be controlled and brought to the service of an active brain; the fortunate possessor is also often musical and, in short, a practical visionary. It is also true that sufferers from a minor degree of hypopituitarism compensate for it by persistent conscientious effort, often in excess of their physical strength. But both the pituitary giant and the Fröhlich tend to lack inhibitions. They may lie and steal and commit offences in a foolish, pointless way, often apparently merely to attract attention. They try to compensate for their feeling of inferiority by a craving for the limelight, and if they cannot achieve this with their social equals, they seek for it from their social inferiors. They are very prone to fantasy-thinking, seeking a dream world in which to escape from this feeling of inferiority. In two cases recently, one in

a girl of only 17, the craving for a child led to fantasies of pregnancy. Another girl stole a gold wrist-watch from a school-fellow, and on her return home for the holidays told her mother it had been given her as a prize for good conduct! The following interesting case came under my notice not long ago: A girl was arrested for shop-lifting. Her doctor told me he was sure that she had an incarcerated pituitary. As she presented no physical stigmata of pituitary disorder, I told him we could not put forward that defence without X-ray evidence. Much to my surprise the skiagram revealed that the anterior and posterior clinoid processes were almost in apposition, showing that the stalk of the pituitary was tightly constricted.

THE INTRADERMAL TUBERCULIN REACTION.

THE variety of tuberculin most commonly employed in the various diagnostic tests is that originally elaborated by Koch and commonly designated O.T. It consists essentially of a glycerin broth culture of tubercle bacilli, human or bovine, incubated for six weeks and filtered, and it therefore contains a mixture of the products of autolysis of the bacilli, consisting chiefly of endotoxin and the proteins of which the organisms are composed. When originally published, the discovery was hailed as an infallible guide to the diagnosis of tuberculosis, but reliance on the result led the earlier investigators into such a maze of error and contradiction that for a period the test fell into disrepute. Of recent years, however, additional work has been performed in many countries, showing that the tuberculin test has a very definite sphere of usefulness, and more especially in the field of veterinary surgery the test has been shown to be at times of great diagnostic value.

In the investigation of human tuberculosis the test has been applied in a great variety of ways, all of which possess some obvious advantages and disadvantages, and in the practical application of the test some knowledge of the common pitfalls is essential to the correct interpretation of the result. The ideal test should possess certain main attributes. It should be simple to perform and the result should be easy to interpret; it must obviously not be harmful to the patient. In addition, the result should convey some clear indication of disease or of its absence; a test which yields positive reactions in a large proportion of healthy adults is of little assistance in clinical diagnosis. The following are the commoner methods in use at the present time:

(1) *The subcutaneous test of Koch.*—For this test the patient must be kept in bed and the temperature carefully recorded at frequent intervals; this is likely to be inconvenient in a large clinic where many patients may need investigation. A subcutaneous injection of 0·1 mgrm. of O.T. is given in the morning. Should no rise of temperature follow upon this first injection the dose is doubled on the following day. If, however, there occurs a rise of temperature, even if no more than 0·5° F., then the dose is not increased, but the same dose is given again after the temperature has returned to normal. Very frequently it becomes evident that the second reaction is more severe than the first, although the dose has remained the same. This is a phenomenon very specially characteristic of the tuberculin effect, and can be regarded as an infallible sign of tuberculosis.

The writer has little practical experience with this test, and is not in a position to express any opinion as to its reliability. It is definitely cumbersome, and the necessary confinement to bed may prove irksome to a patient who feels comparatively well, and in whom the diagnosis may rest only on suspicion.

(2) *The ophthalmo-reaction of Calmette.*—This consists in the instillation of diluted tuberculin into the conjunctival sac. The resultant reaction, if at all severe, may easily be detrimental to the patient, and consequently the test is not often employed—in this country at least.

(3) *The cutaneous reaction of von Pirquet.*—In this test a drop of O.T. is placed on the skin of the patient. A scratch, about 3 mm. in length, is then made through the fluid, but not sufficiently deeply to draw blood. The drop is wiped off after five minutes; the resultant reaction consists, if positive, of an area of redness and swelling at the end of twenty-four hours.

Most observers have found that the majority of adults yield a positive reaction to this test, so that its diagnostic value is not great. A negative finding, on the other hand, will have a correspondingly greater weight in excluding the diagnosis of tuberculosis.

(4) *The intradermal reaction of Mantoux.*—This is the most recent addition to the series of tuberculin tests, and a discussion of its significance is the main object of the present paper.

The most obvious advantage which the test possesses is its uniformity. In each instance, an exact quantity of tuberculin can be placed with certainty in the deeper layers of the skin, so that the resultant reactions in a whole series of patients will be strictly comparable, and the extent and significance of the reaction in any

particular patient can be interpreted with greater accuracy in the light of previous experience.

During the past two years the writer has been engaged upon a clinical investigation of lymphadenoma under the direction of the Rose Lymphadenoma Research Committee.

It has been frequently stated that this disease is really an atypical variety of tuberculosis affecting the lymphatic glandular system, and, although there is little clinical or pathological evidence in support of such a theory, it was considered desirable to subject a series of patients to the tuberculin test, from an unprejudiced point of view, in order to accumulate a further piece of evidence for or against the theory.

The intradermal test was the one finally selected for the purposes of the investigation on account of its simplicity. In addition to cases of lymphadenoma, cases of proved tuberculosis and cases apparently quite free from tuberculous infection were tested simultaneously, in order to control the results obtained in the series under investigation.

As the method was then comparatively recent and little used in this country, a considerable time was spent in working out the conditions under which the most satisfactory results could be achieved. It is unnecessary to detail here the various modifications which were found necessary as the work progressed; the final result and a satisfactory technique are the chief concern of the reader.

In performing the test the following essentials must be kept in mind. In the first place the dose injected must be sufficient to give positive reactions where such reactions should occur, yet it should not be so great as to cause severe reactions in the patients. The tuberculin should be freshly diluted shortly before use. It is stated that diluted tuberculin will give positive reactions if kept for as long as four weeks, and this may be true, but if the solution be kept for any length of time it loses some of its potency and the resultant reaction tends to become weaker. In the tests recorded in this series the tuberculin was never kept for more than forty-eight hours.

Lastly, the site selected for the injection should be carefully considered, not only from the point of view of ease of injection, but also in order that a strongly positive reaction shall not interfere with the function of large joints with consequent avoidable discomfort to the patient.

After considerable preliminary work, and following the experience thus gained, a standard method was evolved which has since been rigidly followed, with, on the whole, satisfactory results. The method is described in detail below:

(*a*) *Preparation of the material.*—A single batch of Koch's old tuberculin was obtained from Messrs. Allen & Hanbury, and this material has been used throughout. On the morning of the test $\frac{1}{10}$ c.c. of this material is diluted with sterile normal saline solution to a concentration of 1 part in 1000 of fluid. Each cubic centimetre of the diluted tuberculin, therefore, contains 1 mgrm. of O.T. At the same time a similar quantity of the control solution, consisting of a sterile glycerin broth, supplied by the same firm, is diluted in exactly the same way and two special tuberculin syringes and intradermal needles are sterilized by boiling.

(*b*) *Injection into the patient.*—After several trials it was found that the forearm is the most suitable site for injection. It is easily accessible, and the skin is fairly thick and easily immobilized. The dose eventually selected and consequently standardized, is $\frac{1}{10}$ c.c. of the 1 in 1000 dilution, equivalent to $\frac{1}{10}$ mgrm. of O.T. This is best injected into the palmar surface of the forearm, midway between the elbow and the wrist. Injection of this material near the elbow-joint should be carefuliy avoided. Occasionally quite severe reactions are obtained even with this small dose, but in no case has any inconvenience been caused to a patient. The control solution should be injected at least 2 in. on the proximal side of the tuberculin injection. In no case was any reaction obtained with the control solution, and this corresponds with the experience of other observers.

In both cases the injection is made into the deeper part of the skin, raising a small wheal which disappears within half an hour. Care should be taken to avoid leakage of tuberculin into the subcutaneous tissues, as unexpected temperature reactions may develop in tuberculous patients if this should occur. As far as the actual technique of the injection is concerned, it differs in no respect from that of intra-cutaneous injections in general.

(*c*) *The reaction.*—As far as the control is concerned, no example of a positive reaction was found, so that discussion can be confined to the tuberculin reaction alone. These reactions were always examined forty-eight hours after the injection had been given, as it was found that the maximum change occurred at this period

The typical positive reaction was found to possess two distinct features: In the centre would be found a pale, rounded swelling which might be slightly tender to the touch, and surrounding this there was usually a circular area of erythema. The relative sizes of these two component features of the reaction varied considerably in the different cases. In the case of strong reactions there might also be some local irritation of the

skin, but general reactions were only observed in three cases in which there was a suspicion that there might have been some subcutaneous leakage of tuberculin.

When reading the reaction separate notes were taken of the extent of the areas of swelling and erythema.

It was found that in some cases they were dissociated, either occurring without the other, and the cases in which this phenomenon was noted were further studied. It was then seen that whereas a simple erythema without swelling was associated with cases which were either doubtful or apparently non-tuberculous, swelling without erythema, on the few occasions on which it occurred, was invariably associated with proven tuberculosis. The importance of this point in reading a reaction is obvious. *Attention must be paid only to the area of swelling, and erythema alone should be disregarded.*

The estimation of the degree of reaction is rather arbitrary, but when the area of swelling is less than 1 cm. in diameter, it may be considered "weak positive"; between 1 and 2 cm. in diameter is the usual finding, and may be classed as "positive." Any reaction in excess of this is rarely found, but may be classed as "strongly positive" when in occurs.

During the past two years many cases have been tested in this manner, and the more significant results will be considered briefly in the following categories:

(1) Cases of proven tuberculosis: In this group are included only cases in which tubercle bacilli could be demonstrated, or at least typical giant-cell systems were present in sections. These cases may be further subdivided as follows:

(i) Pulmonary tuberculosis: Of 9 cases tested, 8 yielded a positive and one a negative reaction. The negative case was one of very acute phthisis and the patient died soon after.

(ii) Tuberculous infection of lymphatic glands: Fifteen cases were tested and all gave positive reactions. It was in this group that the strongest reactions were recorded.

(iii) Tuberculosis elsewhere in the body: Of 7 cases tested, 6 gave positive reactions and one a negative.

(iv) Acute miliary tuberculosis: It has been repeatedly observed that, in the acute state, the intradermal test is negative, and this was confirmed in three cases. On the other hand, in 31 cases of chronic tuberculosis a positive result was obtained 29 times.

(2) Cases which were almost certainly tuberculous: In this group are included cases of pleurisy with effusion, cases diagnosed clinically as tuberculous peritonitis and a few cases of bone and joint disease. Of the 48 cases tested, 42 gave a positive and 6 a negative reaction.

(3) Cases in which no evidence of tuberculosis could be found: This group is the most difficult of all, for it is almost impossible to be sure that there is no tuberculous lesion present, even on post-mortem examination. The cases consisted chiefly of apparently healthy individuals and proved cases of malignant disease, bronchiectasis, diseases of the blood-forming organs, and other cases in which the presence of tuberculosis could be reasonably excluded. In this control series of 103 cases, 29 yielded positive and 74 negative reactions, and it should be noted that the cases in this group were mostly adults.

(4) Cases of lymphadenoma: Of the 40 cases tested, 7 gave positive and 33 negative reactions. In 3 of the 7 positive cases there was evidence of the co-existence of a tuberculous lesion, and the conclusion to be drawn from this series is that, if any importance whatsoever is to be attached to the test, lymphadenoma is not caused by the tubercle bacillus.

Conclusions.

From the results quoted above, it can be seen that in a proved chronic tuberculous lesion the intradermal test is usually found to be positive, whereas in non-tuberculous cases the results are frequently, but not invariably, negative. It must, of course, be remembered that a positive result does not indicate that any given lesion is necessarily tuberculous, for there is nothing to prevent tuberculous disease in one part of the body co-existing with some other lesion elsewhere. In other words the tuberculin test must be interpreted in conjunction with all the other clinical evidence available, and a little experience quickly enables one to assess the weight to be attached to the result in any given case. Employed as an auxiliary in suitable cases the test may prove of considerable value; as a mainstay in diagnosis, however, it is apt to prove untrustworthy.

JAMES MAXWELL.

ACKNOWLEDGMENTS.

The British Journal of Nursing—The British Journal of Venereal Diseases—The Broadway—Bulletin de l'Hôpital Saint-Michel—Caduceus—The Clinical Journal—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The Kenya and East African Medical Journal—The London Hospital Gazette—Long Island Medical Journal—The Medical Journal of Australia—New Troy—The Nursing Times—The Post-Graduate Medical Journal—Revue de Médecine—The Speculum—St. Mary's Hospital Gazette—The Student.

ELYSIAN FIELDS.

"We dwell too much in corners, and, consumed with the petty cares of a bread-and-butter struggle, forget that outside our routine lie Elysian fields into which we may never have wandered, the tillage of which is not done by our hands, but the fruits of which we of the profession fully and freely enjoy."—*Osler.**

IN the autumn of 1927 there returned to this Hospital, which had nursed the tender dreams of his youth, "a very foolish, fond old man, four-score and upward, not an hour more nor less." Though jealous Nature had shorn him of strength and sight, he found solace in filling his darkness with the vagaries of a busy life which had left their perfume in his memory. And lovingly his thoughts must have wandered along noisy Holborn, turned down the "Turnstiles," and crossing the gardens of Lincoln's Inn Fields, entered "The College," which was his spiritual home. In the dusking twilight of his musings, the statue of John Hunter with the dreamy eyes and the fiery brain loomed large before him—patron saint of the Hunterian Museum.

Alban Doran's life-long association with this Museum began in 1873, when, as anatomical assistant to Sir William Flower, he rapidly built up for himself a reputation as a skilled and delicate dissector. The "Doran Collection of Ear Bones" and his scholarly paper "On the Comparative Anatomy of the Auditory Ossicles of the Mammalia" serve as memorials of this period. For eight years Doran worked with Sir James Paget and Sir James Goodhart, compiling the Pathological Catalogue of the Museum. It was work of this kind that brought out Doran's encyclopædic knowledge, his untiring industry in research, his religious attention to minutiæ, his literary skill, and his memory, which was little short of miraculous. His ambition, however, was to become a surgeon in large gynæcological practice. But he had no surgical hands, and his eccentric personality hampered his success as a consultant.

Retiring from practice in 1909, he returned as a volunteer worker to the Museum, where he embarked upon the most ambitious adventure of his life, on which he lavished all his scholarship and energy—the preparation of a descriptive catalogue of the obstetrical and other instruments. This he completed after thirteen years. Overflowing with accurate and learned comments and bristling with odd information it forms a chapter of medical history.† Doran also brought out catalogues of Lister's and Hunter's instruments.*

An incessant talker and an unsurpassed raconteur, whose fund of anecdotes and out-of-the-way knowledge was inexhaustible, Doran was an amusing man and a delightful and entertaining guide to the historical collections, over which he gloated with joy and affection. He took a kindly interest in young people. In the shadow of his small active figure and his pleasantly flowing stream of conversation, the privileged visitor came to regard the galleries of the Museum as Elysian fields, across which he heard the unbroken and melodious echo of the voice of those who have left him the glorious heritage of medicine. The historical excursions with "dear old Doran" always brought solace and sometimes advanced one a little in wisdom; for he was a true guide, who made it his business to rely on the history of medicine for the interpretation of many problems of practice.

When eyesight and bodily health deserted him, Doran was only able to attend the Museum on two days in the week, in order to keep the catalogue up-to-date, and in the last year of his life he obtained the voluntary assistance of Mr. C. J. S. Thompson, recognized authority on the history of medical and surgical appliances, and one who wears the burden of his learning lightly and genially. After Doran's death Mr. Thompson was appointed honorary curator of the historical section of the Museum. The collections to which he gives his voluntary, devoted, and scholarly services could not be in safer custody.

By order of the Council Mr. Thompson has now published a Guide to the surgical instruments and objects in the Historical Series,† which is sold for the modest sum of half-a-crown. Let us take this guide on a hurried tour of inspection. As the collection now numbers over 2000 items, we cannot linger long over individual specimens, but in so far as these illustrate the evolution of a series to which they belong, they arouse our interest and merit our attention. In this quest the little book in our hand is a true guide, with its leading features printed in large fat type. We are interested to watch the development of the scalpel through its Babylonian, Greek, Egyptian, Roman, Arabian and English representatives; and we are attracted by the history of the cautery and of tracheotomy. We enjoy looking at the fistula knife belonging to our old friend, Percival Pott, and his own description,

* *Boston M. and S. J.*, 1891, cxxv, p. 425.

† *The Catalogue of the Obstetrical Instruments* (1921) has been printed, but is not for sale. The remaining volumes are typewritten and can be consulted in the Museum.

* Printed, but not for sale.

† *Museum, Royal College of Surgeons of England: Guide to the Surgical Instruments and Objects in the Historical Series, with their History and Development.* By C. J. S. Thompson, M.B.E. With a foreword by the Conservator, Sir Arthur Keith, M.D., F.R.C.S., F.R.S. Issued by order of the Council. London: Taylor and Francis, 1929. Pp. 92, illustrated. 2s. 6d.

which we are given an opportunity to read, stands out in the mind. We are allowed to catch a glimpse of the fascinating evolution of the obstetric forceps. This, of course, was a subject which Doran had made essentially his own.

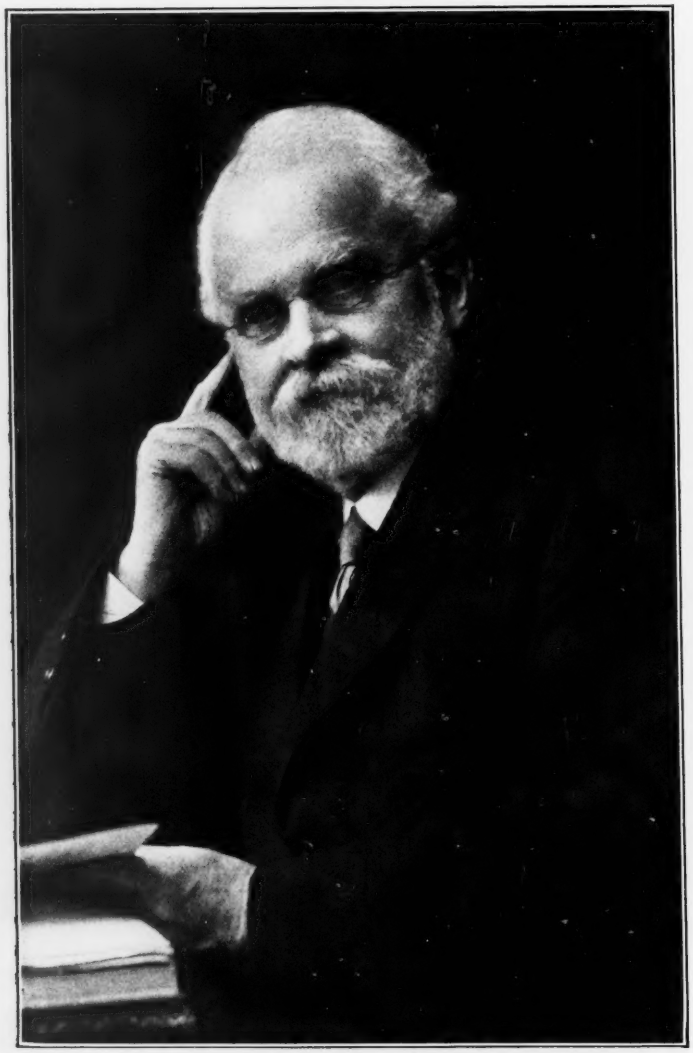


Photo: John Russell & Sons. ALBAN DORAN.

Like the reels of a film, there passes before our eyes the graphic history of the tourniquet, of the trephine, and of the letting of much blood. The cocoanut shell used by barbarous races for receiving blood during venesection changes in this hall of miracles as it were in the twinkling of an eye into a superb pewter bleeding-bowl which is dated 1671, and back again into a striking representation on a Greek vase about 500 B.C. Everywhere in this amazing Valhalla of *memorabilia* we become conscious of the transmutation of the medicine man of the dim past with his few implements and his rich imagination into the Harley Street specialist with his bewildering armamentarium of instruments and drugs. Yet both are the very personification of the spirit of the healing art. How salutary to look down from the height of our experience into the great plain which we have crossed. It is necessary to pause from time to time, if but for a moment, and to survey the long road that stretches into the very origin of time and fades into the mist and into the silence.

The systematic classification and sympathetic grouping of these historical exhibits enables us across the gulf of the years to shake hands with the fathers of medicine who begat us. 'Tis thus we come to regard ourselves but as links in the endless chain of medicine. What an education to glance at the exhibits illustrating the genesis of the clinical thermometer, whose story the guide tells so freshly and so entertainingly! In the seventeenth century Sanctorius constructed the first clinical thermometer, which he used in the diagnosis of disease, correlating variations in body temperature and weight. He got very near to appreciating the meaning of metabolism. John Hunter discovered the significance of the terms "cold-blooded" and "warm-blooded" animals, though he never realized that muscular action is the principal source of animal heat. It did not occur to him to employ the thermometer in disease. The story ends with Sir Clifford Allbutt, who introduced the clinical thermometer as we know it into practice.

The Historical Room proper is still marked "Private"—a grim relic of the days when visitors were indeed intruders, and the Librarian of the College was allowed to occupy a room with a door that locked! But now a visit to the Library is enhanced by the pleasure of meeting Sir D'Arcy Power, who never seems to weary of helping those in trouble, and a visit to the Historical Room by the pleasure of meeting its genial Curator. It is not wise, however, to spend more than half an hour

in this *omnium gatherum*. For mental dyspepsia is the just reward of the indiscreet. Hands of pugilists, shoes once worn by giants, tattooed human skin, chastity girdles, Napoleon's small intestine, phallic charms, the hands of Thomas Beaufort, son of John of Gaunt, shrunken heads—grim trophies which Bland-Sutton brought home from the Amazon! But let us pause before the embalmed body of the first wife of Martin van Butchell, which, arrayed in a garment of fine linen and lace, he piously kept in his sitting-room. In the course of time his affections changed, and there was no room in his house for two wives. This quack-doctor, who was a pupil of John Hunter, was in the habit of riding in Hyde Park on a white pony painted with purple spots.

On our way out just a glance at the exquisite cabinet containing Lister's instruments and manuscripts in Room I and at the Hunterian relics so reverently displayed. This to us seems to be the lesson taught by the history of medicine: That when it really comes to the point the fundamental ethical and humanistic principles of the healing art have changed but little.

The little guide, well printed and illustrated, eloquent of the exploits of the past, appealing to the sympathy of the present, and ever looking ahead into the future, deserves a place in the library of all who take an intelligent pride in their profession. And a few of us who read between the lines "are mightily helped by a dead man's touch." W. R. BETT.

PSITTACOSIS—OR PSUGGESTION.

(*A number of human cases of psittacosis or parrot-fever have lately been reported prominently in the daily Press.*)

WHEN Peter's Poll turns up its toeses
In spite of Peter's hourly doses,
The vet., as Poll in death reposes,
Psuspects it's Psittacosis.

Next day, when foolish Peter blows 'is
Proboscis, which a vivid rose is,
He trembles lest a beak-like nose is
A psign of Psittacosis.

Ere long when Peter in the throes is,
A specialist in diagnosis
Hastens to see what he supposes
Is psurely Psittacosis.

So long the tale of Peter's woes is
His plaintive lips he scarcely closes;
With horrid joy our friend composes
Psagas of Psittacosis.

The doctor then his view discloses:
"*That* Psittacosis! Holy Moses!
You've got what every student knows is
Psimply a psittacine Psychosis."

C. H. A.

MORE "CLERIHEWS."

With apologies to Mr. E. Clerihew Bentley, author of 'Biography for Beginners,' and to numerous other distinguished gentlemen who are—

(*a*) *Included.*

(*b*) *Not included* (*as having unrhymable names*).

Sir H— W—
Is said to be given to swearing
In a rather encouraging way
At the Young Men of To-day.

Sir P— H—
Percusses the thorax so smartly,
And murmurs, "Cough-spit, if you please,
Tibi dabo hirudines tres!"

Sir T— H—
Talks rather like this: "Let us order,
Ung. hyd. ammon. co. (5 per cent.),
For this query-luetic event."

Dr. L— B—
Has a figure well known about Town,
And I'm ready a fortune to wage,
That *he* isn't a "Tachyphage."

Professor F. R. F—
Every Wednesday morning is as keen as a razor;
"It's an awful good show,
But what they all talk about, I don't just know!"

Of Dr. H— H—
It is almost impossible to fall foul,
Even when he sticks pins,
Into innocent shins.

Dr. A. E. G—
Is no longer a bachelor now;
He has taken a wife,
Let us wish him good luck and long life!

You *must* know Dr. G—
His enthusiasm for golf would betray'm.
Does he like C_2H_6O?
"The answer is—No."

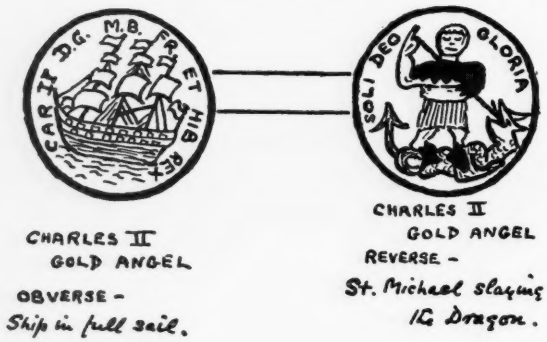
Dr. G— E—
Is seldom at sixes or at sevens
On finding a physical sign,
And, as for his treatment, "It's FINE!"

DISPARU.

THE KING'S EVIL.

THERE began in England in the time of Edward the Confessor, and there ended in Rome at the death of the Cardinal Duke of York, in 1807, the custom of touching for the King's evil.

Among the early descriptions of this custom is that of William Clowes, who was surgeon to Queen Elizabeth and to St. Bartholomew's Hospital. His treatise was called *The Cure of the Malady, called in Latin, Struma, and in English, The Evill, which is Performed by the Kings and Queens of England,* in which he describes a disease which would now be diagnosed as tuberculous infection of lymphatic glands, frequently with sinus formation and superadded pyogenic infection.



For the origin of the custom it is necessary to search deep in the mists of antiquity. Cures of King's evil by Pyrrhus and Vespasian are recorded by Pliny and Tacitus, but according to William of Malmesbury no cures were performed in this country until the reign of the Confessor, and it was not until Henry VII that an elaborate ceremonial was introduced for touching. The ceremony, which was started by Henry VII and which was used with minor alterations by the later kings, consisted in lengthy prayers being said for the sufferer, after which the King would touch the sores and hang a gold touch-piece or Angel round the suppliant's neck.

When James I came to the throne in 1603, he, "the wisest fool in Christendom," refused to perform the rite, regarding it as an idle superstition and akin to witchcraft, and it was only when the popularity of the custom was pointed out to him by his English advisers that he consented to touch.

Charles I appears to have performed a large amount of touching; his touch-pieces bear the legend "Amor populi præsidium regis," *i. e.* "The love of his people is the safeguard of the King." Dr. Raymond Crawfurd, in his book on this subject, says, "As the royalist and republican factions rose steadily to a climax, so the ceremony of healing assumed a greater and greater importance as evidence of the King's Divine Right." In later years, when things were going unhappily with Charles, Sir Charles Wiseman, who was an Army surgeon with the royalist forces, tells us that "small pieces of silver were his gift, for alas he could not arrive to other; 'twas not the golden age with him."

With regard to contemporary medical opinion on the matter, it is of interest to note that Sir Thomas Browne showed no incredulity, and went so far as to send patients to Charles II during his exile and wrote enthusiastic letters to his son describing the Royal Healing, and yet he was the author of *Inquiries into Vulgar and Common Errors,* as well as *Religio Medici.*

Touching was continued with increased popularity till the time of William of Orange, who, to the great delight of Jacobites, refused to have anything to do with it. James Francis, known to some as the "Old Pretender," and to others, who have perhaps a better sense of justice, as James III, touched in exile, and of him Andrew Lang writes, "Had not his very looks proclaimed him to be a King, he had proved his claim by touching for the King's evil at Strathmore's house and all the patients recovered."

The gift of healing was never assumed by the House of Hanover. Robert Chambers, in his *History of the Rebellion,* gives an account of how a partisan of the Hanoverian succession brought his son to George I and asked that he might be touched; George told him to "go over to the Pretender," at which the father changed his politics and a satisfactory cure was performed by James III.

The "Young Pretender" touched at Holyrood, but judging from the great rarity of Charles Edward touch-pieces he could not have performed the rite frequently, and it was left to the "Last of the Stuarts," that is, Prince Charles Edward's brother—the Cardinal Duke of York—the man whose pathetic motto ran, "Angliæ Rex, non desideriis hominum, sed voluntate Dei," to make a final practice of the royal gift of healing in Rome.

Similar ceremonies of healing were performed by the Bourbons and Hapsburgs, and, amazing as it may seem, Stuart relics are kept by many to this day in the fond belief that some healing power may still remain in them.

In conclusion three opinions on the matter may be quoted. Clowes: "A mighty number of his Majesty's most loyal subjects and also many strangers are daily cured and healed, which otherwise would most miserably have perished." Fuller, the Church historian,

says: "If it be the will of God to visit me with the King's evil, I trust I may have the favour to be touched of His Majesty." From the other point of view, Macaulay, in *History of England*, writes: "Theologians of eminent learning, ability and virtue gave sanction of their authority to this mummery; and what is stranger still, medical men of high note believed, or affected to believe in the balsamic virtue of the royal hand."

Thus King's evil is a disease which had probably a greater political importance than any other, for its cure was one of the main props of the Divine Right of Kings, and from its purely medical aspect will remain a subject of interest and speculation; it will always have its supporters and its defamers, being in many ways comparable to the Lourdes of to-day. Possibly Lord Strangford, in the following verse, comes nearest to the right attitude towards such things:

"Oh blame not their blindness,
'Twas the blindness of love
Made them think that this kindness
It came from above.
And when 'twas thus given
To those who had need,
That something of Heaven
Was Majesty's meed."

R. E. M. FAWCETT.

ABERNETHIAN SOCIETY.

A MEETING of the Society was held in the Morbid Histology Laboratory on Thursday, November 28th, at 5.30 p.m., the President, Mr. Hutchinson, in the Chair. The minutes of the last meeting were read and signed.

Dr. T. H. G. Shore gave a demonstration of Museum Specimens from a different point of view. Museums were first built up as collections of specimens of diseased conditions and of organs, and with such collections the idea of teaching became associated. The lecturer proposed to describe and to show certain milestones in the history of our Museum.

The first record is a minute of the Governors, dated June 23rd, 1726: "Two rooms under the 'Cutting Ward' shall be set apart, one as a mortuary, the other as a Repository for Anatomical and Chirurgical Preparations . . . it is likewise ordered that whatever preparation should be given to the repository shall be numbered, and the name of the person who gave it and the history of it be entered in a book to be kept in the Compting House for that purpose. And that Mr. Freke do keep the key of it who shall be accountable for the loss of any preparation; and when he shall decline it the youngest Assistant Surgeon shall do the same." Unfortunately the loss of the book prevents our knowing the number and the nature of the earliest specimens. In the next year Freke was given charge of eye cases, and so, after being the first Curator, became the first Ophthalmic Surgeon at Bart.'s. At this time surgeons and physicians were private teachers, having their own collections, some of which survive in the present-day museums, such as that of John Hunter at the College of Surgeons; the Hospital's own collection was probably quite small.

In 1831 Stanley published the first printed catalogue of the Museum, and there is thus a silent gap of a hundred years except for a few specimens associated with Percival Pott. Two, a carious spine and spinal cord (C.58, T.232) are said to have been mounted by him; two syphilitic calvaria (A.346, A.347) came from the venereal wards in his time, and into the hernia (M.74) Pott is said to have placed the roll of paper. Another carious spine (C.57) was described by Stanley as coming from a case under Pott's care, in which the benefit of "issues" has been demonstrated.

One specimen (M1..69) was taken by Stanley from a man who was wounded at Waterloo, and in 1825 Peter Mere Latham presented a portion of bowel showing dysenteric ulceration.

Stanley's and Abernethy's collections were used quite widely in the Hospital, and in 1828, upon the latter's retirement, the two collections, said to amount to "several thousands," were formally given to the Museum. It was then decreed by the Governors "that teachers are required not to make any separate collection, but to add all preparations and drawings to the said Museum." Stanley, in his Catalogue (1831), described 1613 specimens and wrote of the earlier collections—"Only those morbid specimens have been preserved which might be expected to retain their original characters in a sufficient degree to render them useful as objects of future reference." There was probably a wholesale clearance. Of Abernethy's connection with the Museum three specimens remain to bear witness—a sequestrum in a tibia (A.111), dextrocardia (TE.93) and an innominate aneurysm (F.116).

Stanley, Lawrence, secretary of the Society before it took Abernethy's name, Skey, Wormald, Dr. Bond, Sir George Burrows and Dr. Patrick Black were all represented by specimens, the last three by some early stethoscopes. The next great figure was that of Sir James Paget, Curator from 1837–1843, and his specimens include one of osteitis deformans (A.409). The specimens of the disease of the nipple and the quiet necrosis known by his name were not presented by him, and his preparation of the *Trichina spiralis*, which he had discovered in the dissecting-room and described in a paper to this Society, was thrown away between 1884 and 1889. In 1846 the first volume of the second catalogue was published by Paget, the second volume appearing in 1851.

Two important specimens of septic endocarditis (E.67, E.68) remind us of W. S. Kirkes' historic paper on "Detachment of Fibrinous Deposits from the Interior of the Heart" (*Med.-Chir. Trans.*, 1852). In 1862 Sir William Savory published a supplementary volume to Paget's catalogue. The Museum had been on the site of the present Anatomy Department, but in 1879 a move was made to the newly erected building, where it still remains. At this time Matthews Duncan presented his unique collection of obstetrical specimens, which he had brought with him from Edinburgh, and which include his series of deformed pelves. In 1882 Sir Frederic Eve's catalogue was published, since which time many specimens have been added by the members of the Staff.

The vote of thanks was proposed by Prof. H. KETTLE, who described the feelings of one who had known other museums, and had in this experienced state first come in contact with and under the spell of the wonderful Museum of which Dr. Shore had given so interesting an account. The vote was seconded by Mr. FAWCETT, and carried unanimously.

The Secretaries beg to add that this lecture was particularly difficult to report owing to the varied nature of the exhibits, and that no account could do justice to Dr. Shore's easy delivery of, and light touch with, the solid matter of his discourse.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

As we take up our pen, the sweet odour of Richmond's historic turf gently bathes our nostrils. The shout of forthcoming cup-ties has gone out. It is rumoured that the cup, tired of the cosmopolitan atmosphere of the Borough, has made a wish to take up its residence within the walls of ancient Smithfield.

We hope the Junior Cup will not desire to change its annual home, for we have come to look upon this trophy as being a permanent fixture in the literary surroundings of our Library. Recent games have been most encouraging, for after the 'Quins had been beaten by so decisive a margin, the Old Haileyburians fell an easy prey, and at Gloucester, although beaten, the Hospital put up a remarkably fine performance. On present form it may be safely said that we stand a very strong chance of winning the Cup.

J. M. J.

1ST XV RESULTS.

January 4th: *v.* Harlequins (home), won, 25—11.
January 11th: *v.* Old Haileyburians (home), won, 20—0.
January 18th: *v.* Gloucester (away), lost, 5—11.

1st XV record up to January 18th: Played 16, won 7, drawn 1, lost 8. Points: For 162, against 143.

ST. BARTHOLOMEW'S HOSPITAL *v.* HARLEQUINS.

Result: Bart.'s, 25; Harlequins, 11.

January 4th, at Winchmore Hill.

Owing to the trial game at Twickenham, the Harlequins were without several of their star performers, but even their absence was not sufficient to account for their decisive defeat, for, in the second half, the Hospital showed themselves to be decidedly the better side at all points of the game. In the first half Bart.'s played against the wind and managed, by the extremely capable hooking of Robertson and by the excellent work of the whole pack, to hold their own. The opening stages of the game were rather scrappy, many mistakes being made by both sets of backs. The Hospital had many chances but the passes were dropped; their opponents were little better, and it was not till after twenty minutes' play that movements began to be combined and unspoilt by mistakes. Half-time arrived with the Quins' leading by 8—6.

When Rice-Evans ran through the Hospital side directly after half-time it looked as if the Harlequins would win, even against the wind. But Bart.'s played with magnificent determination. Beilby, standing up closer to Taylor, opened up the game well. Nunn was always the chief schemer for openings, and Powell not only showed great determination in running round Gray on two occasions, but also tackled quite relentlessly. Taylor, to show his adaptability, was also a hero in defence. In the later part of the second half the 'Quins were completely outshone, for the whole of the Bart.'s side had touched the height of their form. We congratulate all on a most spectacular display, won entirely by determination!

Teams.—Bart.'s: T. J. Ryan (*back*); G. F. Petty, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

Harlequins: J. T. Hubbard (*back*); G. B. Gray, J. Hutton, J. M. Rice-Evans, P. E. Hodge (*three-quarters*); H. C. C. Laird, D. M. Phillips (*halves*); D. P. Willis, A. G. Prescott, E. H. Fouraker, M. L. Jackson, C. R. Hinds-Howell, J. H. Sears, B. H. Corker, T. C. Dunkerley (*forwards.*)

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD HAILEYBURIANS.

Result: Bart.'s, 20; Old Haileyburians, 0.

January 11th, at Winchmore Hill.

R. N. Williams and E. M. Darmady were engaged with their counties, while G. F. Petty, having injured his ankle against the Harlequins, was unable to turn out.

At the start the playing conditions were appalling, and they steadily became worse as the game progressed, for the day, which had started with spring-like sunshine, ended by pouring forth rain and snow upon us. The superiority of the Hospital lay undoubtedly at half-back, where J. T. C. Taylor was again in excellent form, and combined well with F. J. Beilby, his stand-off. These two, considering the atrocious conditions which prevailed, did very well, their handling and running being in marked contrast to the fumbling and hesitancy of the Haileyburian pair, who could do little that was right. J. D. Powell opened the scoring with an unconverted try for Bart.'s, which was followed closely after by two excellent tries by Taylor.

In the second half the Haileyburian defence stiffened considerably and their forwards began to carry some of the scrummages, but the Hospital backs soon began to exploit to the full the advantages given them. W. M. Capper, A. H. Grace and Taylor added further tries, one of which Taylor converted. The game, owing to the unkindness of the elements, was wretched and disappointing, and everyone was glad when "no side" was given.

Team: T. J. Ryan (*back*); A. H. Grace, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, J. M. Jackson, J. R. Jenkins, B. S. Lewis, A. T. Blair (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* GLOUCESTER.

Result: Bart.'s 5; Gloucester, 11.

January 18th, at Gloucester.

Bart.'s made the journey to Gloucester without W. M. Capper, who had to stand down on account of a recently vaccinated arm. Gloucester kicked off in fine weather, and on excellent turf; play was evenly contested, but the Gloucester backs were very shaky to begin with. Bart.'s obtained an early success when C. R. Jenkins, after some clever inter-passing movements between the centres, obtained possession and ran through the home defence, without anyone attempting to tackle him; he converted his own try. Gloucester then began to pull together and combined most effectually; in the pack, the home forwards managed to gain possession more often than the Hospital, and their backs had many fine openings, but nothing came of them. The tackling of the whole Bart.'s side was magnificent; time and again many hopeless positions were saved by real cup-tie-like tackling; the centres were especially noteworthy in this respect.

The second half was played at a terrific pace, both packs putting in a number of loose rushes and some gruelling tackling. Bart.'s played well throughout and were unlucky in having so many penalties awarded against them; the chief reason of the Gloucester success was their greater ability to take their chances and the fine display of kicking by Boughton.

Teams.—Bart.'s: T. J. Ryan (*back*); A. H. Grace, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

Gloucester: H. Boughton (*back*); Roy James, M. A. McCanlis, E. W. Lovegrove, R. Baker (*three-quarters*); F. Price, D. Meadows (*halves*); L. E. Saxby, A. Carpenter, T. Hiam, F. Wadley, G. Foulkes, J. Hemming, F. Russell, E. Comley (*forwards*).

CHIEF ASSISTANTS *v.* RESIDENT STAFF.

Result: Chief Assistants, 3; Resident Staff, 8.

January 8th, at Winchmore Hill.

Although not widely advertised within the Hospital, this fixture, a revival of the past, attracted a number of ardent followers of the game to make the unwholesome pilgrimage to Winchmore Hill. We sympathize sincerely with all those who did not see this great attraction, for it was one of those rare occasions when the mighty come down from their exalted positions and take part in the happenings of the democracy.

The Residents, ably led by C. R. Jenkins, kicked off in perfect conditions and before an enthusiastic gate. The opening play was chiefly in the Resident Staff's half, and remained there till a free kick was awarded against the "Clinicals" for deliberate picking out of the scrum (we mention no names). C. H. Taylor (a relic of the "B" XV), with a beautiful kick and follow up, brought play back to the Clinicals' "25." Lloyd-Williamson brought off a spectacular movement which nearly ended in a try; he was, however, tackled and the ball went loose. The Residents continued to press for about five minutes, and it was not till Briggs (a temporary clinical assistant) secured possession of the ball that play was brought to the half-way line. B. B. Hosford from some unknown source gained possession of the ball and completely outstripped the majority of the Residents' defence; he was finally tackled, and after a bit of very suspicious work on the part of the residents the referee (a well-known north-country professional) awarded a penalty. D. J. Stephens, temporarily forgetting his old age, managed to kick a splendid goal. Such a reverse completely lowered the prestige of the Residents, and the Clinicals (sometimes known as the "Asses") held the superiority for a time. Carmichael brought off a magnificent kick to touch, but at this stage of the game play had to be momentarily suspended while B. B. Hosford was moved to full back on account of nausea; Briggs came up to the forward ranks. On resuming play the Residents, having recovered from the success of the Clinicals, managed to exert themselves. Lloyd-Williamson, after a pass from Taylor, raced down the touch like Pegasus, to score a magnificent try for the Residents between the posts. Jenkins had no difficulty in converting. Half-time was then given.

Score: Resident Staff, 5; Chief Assistants, 3.

On changing over the Clinicals kicked off, but Jenkins, who should have known better, fumbled badly and play settled down in the Residents' half. A series of penalties was awarded against the Residents; these were taken by Stephens, who gained much ground by his fine kicking, but Taylor relieved the pressure with a breakaway. He was eventually tackled by Briggs and the ball went loose. Bennett, however, soon afterwards obtained a pass from a forward and managed to score for the Residents fairly far out; Jenkins was unable to convert. For the remainder of the game play was very keenly contested, with the Clinicals pressing hard. On more than one occasion they were unlucky not to score, but the deadly tackling of Nicholson, Rait-Smith and others kept the Residents' line intact. Some consternation was shown at intervals by certain of the spectators as to the referee's decisions, but on the whole we consider

he performed his functions satisfactorily, and we congratulate all on an extremely amusing game.

Teams.—Chief Assistants: G. D. S. Briggs (*back*); J. F. Varley, H. Burt-White, E. A. Carmichael (capt.), A. Clarke (*three-quarters*); C. F. Watts, D. B. Games (*halves*); B. B. Hosford, J. H. Hosford, K. M. Ross (representing J. Paterson Ross), G. H. Bradshaw, T. Meyrick-Thomas, D. J. Stephens, P. J. Richards, R. F. Phillips (*forwards*).

Resident Staff: H. V. Knight (*back*); J. C. F. Lloyd-Williamson, M. L. Kreitmayer, C. H. Taylor, E. C. Darke (*three-quarters*); B. Rait-Smith, W. Buckley (halves); J. H. Attwood, F. Ward, W. A. Nicholson, E. G. Recordon, F. A. Richards, A. Bennett, A. M. Boyd, C. R. Jenkins (capt.) (*forwards*).

Referee: J. T. C. Taylor.

SAILING CLUB.

The Annual General Meeting and Dinner of the United Hospitals Sailing Club were held at the Café Chantecler on November 28th 1929, Dr. T. S. Nelson, of St. George's, being in the chair.

By an almost unanimous vote it was decided that the club head-quarters should remain at Burnham-on-Crouch.

A cup was gratefully accepted from A. W. Bourne, Esq., F.R.C.S., to be competed for by the individual hospitals on the basis of points gained in the various races held by the Club throughout the year. It was further decided to paint the dinghies different distinguishing colours for the coming season, and a sub-committee was appointed to inquire into and prepare schemes for the establishment of some form of club accommodation for members at Burnham. Since the meeting the committee has studied the possibility of renting a shed on the river bank, at present used as a store, which can readily be converted into a club-house with sleeping accommodation for a few members. It is hoped that this scheme may shortly be put into execution.

The following flag officers were elected for the coming season: Commodore, Dr. T. S. Nelson (St. George's); Vice-Commodore, W. H. Ogilvie, Esq. (Guy's); Rear-Commodore, F. S. Cleminson, Esq. (Middlesex).

About 47 members were present at the dinner. All the flag officers of the St. Bartholomew's section of the club were present, but the ordinary Bart.'s members were unfortunately very poorly represented, although a large number had promised to turn up. This must be rectified this year.

P. de G. Benson, Esq., Rear-Commodore of the Royal Corinthian Yacht Club, H. Warwick-Smith, Esq., Rear-Commodore of the Royal Burnham Yacht Club, A. F. Challis, Esq., Vice-Commodore of the Crouch Yacht Club, Richard Davis, Esq., and A. W. Bourne Esq., F.R.C.S., were present as guests of the Club.

Suitable speeches were made by the flag officers and the recipients of the Sherran, Wilson and Ogilvie cups, and after the flag officers had been toasted most effectively by "Gentlemen of the Port and Starboard Watches" respectively (the gentlemen of the starboard watch winning easily), a very happy evening was successfully concluded.

Several of last year's members have now left the Hospital. It is hoped there will be plenty of new members. Anyone interested in sailing, and not necessarily only those who are already accomplished helmsmen, are welcome. The Club is proposing to organize a week on the Norfolk Broads in April, the purpose being to teach anyone interested how to sail a boat. The expenses for a week are £4. This includes railway fare, hire of a cabin cruising boat and food. Anyone who has not experienced the Broads in the spring should not miss this opportunity, as it is a wonderful holiday. Anyone wishing to come should give his name to the secretary, who will then make the necessary arrangements.

J. HOPTON,
Hon. Sec.

REVIEWS.

HOSPITALS AND THE STATE. By R. W. CHALMERS, M.B., Ch.B. (London: John Bale, Sons & Danielsson, 1929.) Pp. ix + 143. Price 6*s.* 8*d.* net.

The burning question of "voluntaryism" or State control is nowhere more acute than in the hospital world, and to all who are interested, and who desire a sound knowledge of the case, this book will prove to be valuable and well worth reading. The writer deals fairly with most of the obvious problems, and compels the reader to face the essential facts at the beginning, by realizing first that "State assistance and State control has become established as an inherent and inevitable part of our social progress, and the growth of the humanitarian spirit."

The historical survey, which occupies a considerable part of the book, is full of interest, and the important part played by leprosy and plague in demonstrating the necessity for public responsibility and public control of disease is made clear as the result of the limit of capacity of private hospitality and philanthropy being exceeded. Once the acceptance of public responsibility for shelter and isolation of the sick was established, the extension of that responsibility to include the *cure* as well as the *care* was inevitable.

The early stages of the Poor Law in the form of "measures for policing the victims of destitution" are made clear. State interference and State control in their incipient form began by dividing the poor into those who could work and those who were in the stage of helplessness through age, infirmity or disease, and by dealing with the latter class first by organized charity, and subsequently by compulsory assessment. The repressions and degradations of the labourer, which reached a climax in the reign of Elizabeth, are shown to have played their part in compelling the State to interfere on behalf of the distressed and the destitute, even while the mediæval hospitals, with their amazing accompaniments of superstition and trickery, were establishing those foundations of voluntaryism and charity upon which the modern voluntary hospital is built. An excellent condensed account of the Great Plague in London in 1665 and its effect upon the problem is given. From the earliest times hospitals have received State support and have been in some degree subordinate to the State, and the early associations between "Bart.'s" and the City of London are mentioned.

In dealing with the development of the Poor Law generally the author has wisely drawn largely from the writings of Mr. and Mrs. Sidney Webb, whose words are quoted, and to whose books the reader desirous of pursuing the subject is referred. Regarding the Commonwealth the writer makes the remark that "The period was significant in all those political ideals and changes which made it the source of those distinctively democratic developments which ultimately were brought to bear in after years upon the problems of the poor, and the question of State intervention.

The book covers an extraordinarily wide field and makes interesting reading all through. Its value, however, would have been greatly enhanced by a good index, which is badly needed.

Everybody associated with hospital work or interested in the problem will do well to read everything in this little book.

RECENT ADVANCES IN CARDIOLOGY. By C. F. TERENCE EAST, M.D., F.R.C.P., and C. W. CURTIS BAIN, M.C., M.B.(Oxon.), M.R.C.P. (London: J. & A. Churchill, 1929.) Pp. 342. 12 plates and 57 text-figures. Price 12*s.* 6*d.*

The authors of this excellent book showed great width of vision when they decided that "cardiology" should mean a study of the circulation as a whole, and that "recent advances" should be interpreted as the progress made during the last twenty-five years.

This breadth of view has resulted in a book which is essentially practical, and, as far as present knowledge allows, serves the clinical and therapeutic needs of the day.

A mass of material has been collected into a well-written, orderly and restrained whole. Controversial points are clearly stated in each chapter, and followed by a guarded but definite opinion as to the most likely truth.

Academic material has not been excluded. Considerable detail is given throughout on electro-cardiographic findings, but these are relegated to their proper place and not allowed to prejudice the general interest.

The authors are well aware that in diagnosis and prognosis, knowledge gained by instrumental aid must be subsidiary to the facts of accurate clinical observation. In other words, the machine must not, as in *Erehwon*, be master of the man, and the dangers of accepting electro-cardiographic manifestations without correlating them with the condition of the patient is well shown in the chapter on evidences of myocardial disease.

It is not possible in the space of this review to discuss in detail the various chapters, but only to mention a few points.

The second chapter on thrombosis of the coronary arteries and myocardial infarction is certainly one of the best in the book. The clinical picture is stated in a particularly clear and lucid way. So, also, with angina pectoris, where no half-hearted diagnoses, such as pseudo-angina, etc., are tolerated.

Cardiac irregularities are classified in an original and attractive form, and stress is laid on the importance of regarding them as symptoms of disease, and not as maladies in themselves.

The use of digitalis and quinidine in the treatment of cardiac disorder receives good handling, and the vexed question of giving morphia in heart failure is discussed and receives the authors' blessing. Unfortunately, the still more debated question of administering alcohol is dismissed in a few lines.

It is to be regretted that the chapter on infective endocarditis, rheumatism and cardiac syphilis is not of greater length. For instance, the question of mitral regurgitation occurring without stenosis in rheumatism is not mentioned.

It is refreshing to read that the arseno-benzole may be given with safety in syphilitic carditis. The danger of so doing has too long been a bugbear to the physician.

But it is the last few chapters that will make the greatest appeal to the clinician. They deal with a variety of subjects, from hyperpiesia to the condition of the heart in pneumonia, and include a chapter on examination of the heart and aorta by X-rays.

The scope of the book might be still further extended, in the next edition, to include a chapter on the influenzal heart.

The diagnosis of the healthy heart brings a good book to a fitting conclusion.

ACUTE INFECTIOUS DISEASES. A Handbook for Practitioners and Students. By J. D. ROLLESTON, M.D., M.R.C.P., F.S.A. Second edition, revised and enlarged. (London: William Heinemann [Medical Books] Ltd., 1929.) Pp. ix + 419. Price 15s. net.

Instruction in the diagnosis and treatment of "fevers" has been enclosed by force of sanitary circumstance within a special three months' course. The student inevitably approaches the subject as one out of relation with the general body of medicine, and the effect of separation is heightened by such characters as self-limitation, known incubation period, definite skin signs, which mark the disease process. The more necessary is it that he should choose to read a book which deals with acute infectious diseases in their widest sense.

Such a book is this of Dr. Rolleston's, the publication of the second edition of which means, we hope, that it has become a permanent member of the household of standard text-books. The accounts of the diseases, as is to be expected from so experienced a teacher and writer, are full and clear, and the "reference" lists are valuable for collateral reading. The author is especially to be congratulated upon the historical introductions, which are long enough to contain the main events, and short enough to hold the attention of the unhistorical.

The book is well produced, makes excellent reading, and is to be recommended both to students, as a guide to their clinical observations, and to practitioners, as a reliable source for reference.

A MANUAL OF MIDWIFERY. By HENRY JELLETT, M.D., F.R.C.P.I., and DAVID G. MADILL, M.B., B.Ch. Fourth edition. (London: Baillière, Tindall & Cox, 1929.) Pp. xii + 1281. Illustrated. Price 25s. net.

From the examination point of view the midwifery text-book is often regarded as easy prey—to read up surgery or medicine a week before an examination is a hopeless task, but to cover midwifery is not impossible. The book is not so long as the others, and after all the thing goes with something of a swing about it. The start may be somewhat sluggish as the anatomy and physiology are mastered; the pace may become well-nigh non-existent as the embryology is reached; but having coped with—or skipped—the Müllerian mist of uncertainty, progress is rapidly made.

But Jellett and Madill is no cram-book and is not to be hustled in this way. For ordinary examination purposes therefore it is not to be recommended, but as a work of reference to be consumed leisurely and inwardly digested it is a remarkably sound investment.

The fourth edition is a wonderfully comprehensive work. It contains well over 1000 pages and every conceivable obstetrical subject is dealt with.

The sections new to this edition are those on anæsthesia in labour, pyelitis during pregnancy, nephritis, toxæmia and pre-eclamptic toxæmia. The treatment of these subjects is orthodox, and no special point of interest is raised.

The sections on eclampsia, the treatment of contracted pelvis and the ætiology of ante-partum hæmorrhage have been rewritten.

The book can be thoroughly recommended to those who wish to delve a little more deeply into obstetrics than is necessary for ordinary pass examination purposes.

UNDULANT FEVER. By Capt. W. DALRYMPLE-CHAMPNEYS, M.A., D.M.(Oxon.), M.R.C.P.(Lond.). (London: H.M. Stationery Office, 1929). Pp. 78. Price 1s. 6d. net.

The subject of undulant fever is one of growing importance. At one time thought to be confined to the shores of the Mediterranean, it is now seen to be appearing in nearly every part of the world.

The concise account of the disease given in this monograph is, therefore, both timely and welcome.

The author first gives an historical survey, followed by a clinical account of Mediterranean fever. Then follows a description of the disease as seen in other countries. He shows that the causative organism in these cases, the *Br. abortus*, may be conveyed not only by goats, but by a variety of other animals, chief among which are cattle. He considers that the organism of Mediterranean fever and those carried by the others differ only in the slightest degree, or are even perhaps merely different members of one species.

Only fourteen cases of undulant fever contracted in this country have been recorded, and contagious abortion due to the *Br. abortus* is prevalent among cattle. This might lead one to suppose that humans were more or less immune to the British strain of organisms found in infected cattle. But here the author sounds a note of warning, and thinks it possible that the incidence in this country may be much higher than supposed, owing to the difficulties of diagnosis.

A very extensive bibliography concludes this valuable book.

MOTHERCRAFT. By LESLIE GEORGE HOUSDEN, M.B., B.S. (London: Herbert Jenkins, 1929.) Pp. 122 + index. Price 2s. 6d. net.

The results of efficient ante-natal care and rearing a child depend not only on medical advice, but on an enlightened public. This book is an honest attempt to educate the mother and for that reason serves a useful purpose. The book is written in a chatty manner and contains no new thoughts. The author insists on the importance of ante-natal care, but devotes little space to this matter. Very rightly he stresses the importance of breast-feeding, and shows how most failures in this direction are preventable. There is no doubt that this book can be of use to expectant mothers.

MANUAL OF PHARMACOLOGY. By W. E. DIXON, M.D., F.R.S. Seventh edition. (London: Edward Arnold & Co., 1930.) Price 18s. net.

The latest edition of this excellent manual retains the main characteristics of its predecessors in being both interesting and easy to read. For those commencing the study of pharmacology, the opening chapters contain a series of definitions, which clear up many of the initial difficulties of the subject. For others, the method of describing each group of drugs according to the same plan makes reference to it simple and rapid. Not content with clear and concise descriptions, the author has included many tracings of actual experiments to illustrate the salient points, and where possible a series of simple diagrams is used to show the points of action of the various drugs.

The statement in the preface that "the present edition of the manual has been completely revised in conformity with recent knowledge" is borne out by paragraphs on ephedrine, ultra-violet light and radium. A list of the better-known patent medicines, together with their constituents, which is included, is not only of interest, but also of practical value in these days, when many patients try out this type of medicament before consulting their medical adviser.

The edition will enhance still further the book's reputation earned by its predecessors as an essential both to student and to practitioner.

CLINICAL METHODS. A Guide to the Practical Study of Medicine. By ROBERT HUTCHISON, M.D., F.R.C.P., and DONALD HUNTER, M.D., F.R.C.P. Ninth edition, revised throughout. (London: Cassell & Co., Ltd., 1929.) Illustrated. Pp. xii + 684. Price 12s. 6d. net.

Laënnec published a two-volume *Traité de l'Auscultation médiate* to be sold with his invention, the stethoscope. It is a pity that the book is no longer bought together with the instrument, or failing that, that Gee's *Auscultation and Percussion* has not taken its place.

The next best thing, which should be bought after the stethoscope and certainly before the knee-jerk hammer, is this little book. It has been said that everyone ought to read it through once in six months, and with this dictum we are inclined to agree.

For the ninth edition the chapters on the Central Nervous System and on the Examination of Pathological Fluids have been revised, and that on Bacteriological Investigations rewritten at shorter length, so that the book is smaller by a few pages than the previous edition.

Hutchison and Rainy, or, as we must learn to call it, Hutchison and Hunter, is one of the indispensables in the outfit of every medical student.

THE EYE IN GENERAL MEDICINE. By A. MAITLAND RAMSAY, M.D. (London: Baillière, Tindall & Cox, 1929.) Pp. x + 255. Price 12*s.* 6*d.* net.

Since the introduction of the ophthalmoscope it has been possible, thanks to the accessibility of the eye and to the transparency and the high magnifying power of its media, to observe pathological processes in the living human body as they had never been observed before. Moreover, the eye is not an organ to be considered apart from the rest of the body. "The eye is not only in the body, but it is also of the body." Many of its diseases are simply a part of a general pathological process and may give the only, or at any rate the earliest clues to the correct diagnosis. The natural corollary is that it is useless to treat these conditions locally without also treating the body as a whole. In urging these two fundamental points the author is helping to bring together the sciences of medicine and ophthalmology, which cannot be considered separately without detriment to both.

The author urges a closer study of ocular symptoms and of such subjective tests as those for the threshold of light and for light difference, which may give indications of disease before there is any visible change in the retina. The appearance of the retina is liable to so much variation within normal limits that many slight changes which are described in this book could be appreciated only by the expert.

The book is written in a stimulating manner, and if it convinces the medical practitioner that he is working in the dark if he does not carry an electric ophthalmoscope as part of his equipment, it will not have been written in vain.

A COURSE IN PRACTICAL BIOCHEMISTRY FOR STUDENTS OF MEDICINE. By A. T. CAMERON and F. D. WHITE. (London: J. & A. Churchill, 1930.) Price 8*s.* 6*d.*

This new book on practical biochemistry has one great advantage over the many already in existence, and that is, although consisting only of just over 200 pages of actual text, it adequately covers the course required for the 2nd M.B., leaving out all superfluous detail.

The arrangement is on familiar lines, but the matter is absolutely up to date. A commendable attempt has been made to group together the quantitative estimations under particular headings, useful alike to both student and teacher. The book is exceedingly well printed, and has four plates and twenty-three text-figures.

An innovation, which to the reviewer seems rather unnecessary, is the inclusion of an appendix giving first-aid procedures for laboratory accidents.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

KING, H. H., M.B., B.S., I.M.S. (and PANDIT, C. G., M.B., B.S., Ph.D., D.P.H., D.T.M., MENON, K. P., L.M.&S., L.R.C.P.&S., and IYER, P. V. SEETHARAMA, M.A.). "A House-to-House Filariasis Survey in Saidapet, 1927–1928, and a Note on the Source of Filarial Infection in Mosquitoes." *Indian Journal of Medical Research*, October, 1929.

LOVATT EVANS, C., D.Sc., M.R.C.S., L.R.C.P., F.R.S. Editor of Starling's *Principles of Human Physiology*, 5th edition. London: J. & A. Churchill, 1930.

MANSELL, R. A., M.B.E., R.A.M.C. "A Sanitary Soporific." *Journal Royal Army Medical Corps*, October, 1929.

MAXWELL, JAMES L., M.D. "Leprosy in China—an Emigration Problem." *Leprosy Notes*, October, 1929.

MAXWELL, J. PRESTON, M.D., F.R.C.S., J.L.(Lin.). "On Uterine Casts." *Journal of Obstetrics and Gynæcology, British Empire*, Autumn No., 1929.

MOIR, E. D., F.R.C.S. *See* GASK AND MOIR, January No.

MYERS, BERNARD, M.D., M.R.C.P. "Oral Administration of Pituitary Gland." *British Medical Journal*, September 21st, 1929.

NICOL, W. D., M.R.C.S., L.R.C.P., D.P.M. "The Treatment of General Paralysis by Malaria." *British Journal of Venereal Diseases*, April, 1929.

OSMOND, T. E., M.B. "Interpretation of the Wassermann Reaction in Adults.—II. Positive, Negative, and Doubtful Reactions." *Lancet*, September 28th, 1929.

PARSONS, F. B., M.B., M.R.C.P. "Some Pharmacological Aspects of Avertin." *British Medical Journal*, October 19th, 1929.

POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Epoch-Making Books in British Surgery.—X. Hunter's Operation for the Cure of Aneurysm." *British Journal of Surgery*, October, 1929.

RAWLING, L. BATHE, B.A., M.B., B.Ch., F.R.C.S. *Landmarks and Surface Markings of the Human Body*. 7th edition. London: H. K. Lewis & Co., 1929.

RIDOUT, C. A. S., M.S., F.R.C.S. "Ulceration of Larynx: Case for Diagnosis." *Proceedings of the Royal Society of Medicine*, October, 1929.

ROLLESTON, Sir HUMPHRY, Bart., K.C.B., M.D., F.R.C.P. "Medical Societies: Their Origin and Value." *Lancet*, October 5th, 1929.

——— *Sir Clifford Allbutt: A Memoir*. London: Macmillan & Co., 1929.

ROTH, E. J. H., M.R.C.S., L.R.C.P., D.M.R.E.(Camb.). "The Mecapion: An Ionization Apparatus for the Absolute Measurement of X-Ray Dose." *British Institute of Radiology Exhibition*, December, 1929.

RUSSELL, H. G. BEDFORD, M.A., B.Ch., F.R.C.S. *See* HARMER AND RUSSELL, January No.

SELWYN-CLARKE, P. S., *M.C.*, M.D., M.R.C.P., D.P.H., D.T.M.&H. *Report on the Yellow Fever Conference at Dakar*, 1928. Gold Coast Government Printing Office, 1929.

SLOT, GERALD M., M.D., M.R.C.P., D.P.H. "Some Aspects of Rheumatism in Childhood." *Clinical Journal*, September 25th, 1929.

TAIT, C. B. V., M.R.C.S. (Sir PHILIP MANSON-BAHR, D.S.O., M.D., F.R.C.P., and C. B. V. T.). "On the Symptomatology of Intestinal Amœbiasis Based on a Study of 150 Cases." *Lancet*, November 16th, 1929.

THURSFIELD, HUGH D. M., F.R.C.P. Discussion on the Indication for and the Results of Splenectomy. *Proceedings of the Royal Society of Medicine*, September, 1929.

TWEEDIE, A. R., F.R.C.S. "Apparatus for Control of Conversation Test." *Proceedings of the Royal Society of Medicine*, October, 1929.

WALKER, KENNETH, F.R.C.S. "The Interpretation of Tests of Sterility and Fertility in the Male." *Lancet*, November 9th, 1929.

WARING, Sir HOLBURT, M.S., F.R.C.S. Discussion on the Indication for and the Results of Splenectomy. *Proceedings of the Royal Society of Medicine*, September, 1929.

WEBER, F. PARKES, M.D., F.R.C.P. Discussion on the Indication for and the Results of Splenectomy. *Proceedings of the Royal Society of Medicine*, September, 1929.

YATES, A. LOWNDES, M.D., F.R.C.S.(Edin.). "The Evolution of the Sense of Hearing." *Proceedings of the Royal Society of Medicine*, September, 1929.

CORRESPONDENCE.

BRUCELLA ABORTUS IN NEW ZEALAND.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I read with great interest Drs. Bloxsome and Davey's article on a "Case of *Brucella abortus* Infection in Man" in the JOURNAL of September, 1929, as it arrived by the same post as a report from the Auckland Hospital to the effect that the blood of a patient of mine agglutinated *Br. abortus*.

This patient was a boy of 12, who had a practically continuous pyrexia for about 9 weeks. Symptoms were few apart from headache and langour. The only physical signs were a furred tongue, some distension of the abdomen and tenderness over the cæcum. The highest titre to *Br. abortus* was 1–2560. In this case there was a definite history of contact with cows suffering from contagious abortion and drinking their milk unboiled.

The only treatment, apart from symptomatic, given was salol and dimol by mouth, and the boy is now convalescent.

Three cases in this country have been reported in the *New Zealand Medical Journal* of August, 1929, by Drs. Gilmour and Ludbrook, and my case is, as far as I know, the fourth.

Yours faithfully,
L. J. FORMAN BULL.

Pukekohe, N.Z.;
December, 1929.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I suggest that the solid black lettering in which the Resident Staff names are inscribed adds a funereal touch to an already well-shaded corner.

Why not red for the surgeons—blood; blue for the physicians—cyanosis; and green for the anæsthetists— ?

I am,
Yours,
AN ADMIRER.

To the Editor, 'St. Bartholomew's Hospital Journal.'

SIR,—May I recommend Arnold Bennett's *Lord Raingo* to Bart.'s men for a comprehensive and vivid clinical picture of lobar pneumonia with its complications?

Would we could have all our medical fare dished up so attractively!

I am, Sir,
Yours very truly,
M. MUNDY.

Kensal Green, N.W. 10;
December, 1929.

EXAMINATIONS, ETC.

University of Oxford.

Final Examination for the B.M., B.Ch., December, 1929.

Materia Medica.—Brunyate, W. D. T., Nunn, J. A., Scott, R. B.
Pathology.—Jenkins, J. E.
Forensic Medicine and Public Health.—Brunyate, W. D. T., Duncan, C. M., Hawking, F., McMenemey, W. H., Newton, R. D.
Medicine, Surgery and Midwifery.—Duncan, C. M.

University of Cambridge.

Second Examination for Medical and Surgical Degrees, December, 1929.

Part II. Human Anatomy and Physiology.—Bray, J. S. B., Saigol, A. T., Saunders, S. B. H.

Third Examination for Medical and Surgical Degrees, December, 1929.

Part I. Surgery, Midwifery and Gynæcology.—Barnsley, R. E., Fordham, M. S. M., Franklin, A. W., Hancock, P. E. T., Harris, A. G. J., Hobday, F. T. J., Knight, H. V., Nicholson, B. C., Orr, R. G., Prowse, C. B.
Part II. Principles and Practice of Physic, Pathology and Pharmacology.—Fox, P. H., Gurney, A. H., Helme, A. C. de B., Hensman, J. S., Hutchinson, H. P., Neill, E. J., Wood-Smith, F. G., Wright, B.

University of London.

M.D. Examination, December, 1929.

Branch I. Medicine.—Eyton-Jones, F. M. M., Hosford, B. B.
Branch V. State Medicine.—Brocklehurst, G. L.

First Examination for Medical Degrees, December, 1929.

Pass.—Conway-Hughes, J. H. L., David, J. E. A., Evans, D. M., Kennedy, A. R., Lavy, R. E., MacCarthy, D. de la C., Norman, G. H. G., Tregaskis, T. G., Yates, F. H.

CHANGES OF ADDRESS.

BRAIMBRIDGE, C. V., c/o Glyn, Mills & Co., Holt's Branch, 3, Whitehall Place, S.W. 1.
BRANSON, W. P. S., 16, Brunner Close, N.W. 11.
CROOK, E. A., 99, Harley Street, W. 1. (Tel. Welbeck 6450.)
FLEMING, Lt.-Col. J. K. S., I.M.S. (retired), 14, Tite Street, Chelsea, S.W.
GURNEY-DIXON, S., 7, The Close, Winchester.
HADFIELD, G., Pathological Department, Royal Free Hospital, Gray's Inn Road, W.C. 1.
JONES, W. BLACK, "Penderi," Creigiau, Cardiff.
KEYNES, G. L., 11, Arkwright Road, Hampstead, N.W. 3. (Tel. Hampstead 3923.)
McDONAGH, J. E. R., 42, Wimpole Street, W. 1. (Tel. Welbeck 6847.)

APPOINTMENTS.

CHAMBERLAIN, A. G., M.R.C.S., L.R.C.P., appointed Medical Officer to the Bridport Hospital.
EDDISON, F. R., M.R.C.S., L.R.C.P., appointed Coroner for the Northern District of the North Riding of Yorkshire.
STEWART, G. G., M.R.C.S., L.R.C.P., D.P.H., appointed Assistant Medical Officer of Health and Assistant School Medical Officer, Hendon Urban District Council, Public Health Department, The Burroughs, Hendon.

BIRTHS.

TELFER.—On January 14th, 1930, to Dr. and Mrs. A. C. D. Telfer, of 18, Howard Road, Walthamstow, London, E. 17—a daughter.
WILLCOCKS.—On Christmas Day, 1929, at Springfield, Chelmsford, to Hope, wife of Dr. R. W. Willcocks—a daughter.

MARRIAGES.

BRIDGES—BROOKE-SHORT.—On December 28th, 1929, at South Kensington, E. Chittenden Bridges, M.D., of 36, Ashburn Place, S.W., to Mrs. M. Brooke-Short, of 7, Egerton Court, S.W.
WILLOUGHBY—McEWEN.—On January 15th, 1930, at All Souls', Langham Place, W. 1, Hugh Mason Willoughby, Surgeon Lieutenant, R.N.V.R., only son of Dr. and Mrs. W. M. Willoughby, of Woking, to Kathleen, younger daughter of the late John McEwen and of Mrs. E. H. McEwen, of Hong-Kong.
WOOD—BOSTON.—On December 28th, 1929, at Birkdale, by the Rev. Harry Bisseker, M.A., Wilfrid Burton Wood, M.D., son of Peter F. Wood, of Chislehurst, to Lucy Heald Sutcliffe Boston, daughter of Mrs. John Boston, of Birkdale, Southport.

DEATHS.

FRANCIS.—On December 21st, 1929, at Colombo, Ceylon, Thomas Evans Francis, O.B.E., M.D., of Woodleigh, Huddersfield Road, Barnsley, aged 47.
PALGRAVE SIMPSON.—On January 4th, 1930, at Chilland, near Winchester, Hants, Reginald Palgrave Simpson, M.D. (late of Weymouth, Dorset), aged 85.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor,* ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, E.C. 1.

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All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to* ADVERTISEMENT MANAGER, *The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: National 4444.